

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10226

10221

CERTIFICATE OF DEATH

Dr. Gramse

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 82 Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 661 Fitzwater St		1	
3. NAME OF DECEASED (First) (Middle) (Last) HETTIE (Unk) ADAMS				4. DATE OF DEATH (Month) (Day) (Year) Oct. 12 th 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 11, 1882		9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own Home		11. BIRTHPLACE (State or foreign country) R.D. # Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ennis				14. MOTHER'S MAIDEN NAME Laura Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Carroll Adams (Son) Salisbury, Md. 7171 Roger St.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						3 days	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 10/12		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/19, 1955, to 10/12, 1955, That I last saw the deceased alive on 10/12, 1955, and that death occurred at 10:50 A.M. from the causes and on the date stated above.							
SIGNATURE E. R. Gramse				DATE SIGNED Oct. 13 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				NAME OF CEMETERY OR CREMATORY Shad Point Cemetery			
DATE THEREOF Oct. 14, 1955		LOCATION (City, town, or county) (State) Near Salisbury Md (Shad Point Md)					
24. REC'D BY REGISTRAR Oct. 14, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
				ADDRESS SALISBURY MARYLAND			

RECEIVED

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

OFFICE OF VITAL RECORDS AND STATISTICS

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

1955

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		White		1920		New York		1955		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of completion		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
Jane Doe		Wife		123 Main St		New York		New York		10001		1955		[Signature]		Registrar		New York		123-4567		123-4567	

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OCT 14 1955

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U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10227

10222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		Most of life		TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
At home - 801 W. Main St.				801 W. Main Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
Martha Purnell Anderson				10-30-1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	A.A.	Widow	1880	75 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		Cook		Salisbury, Wicomico Co., Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jacob Jones				Sallie Hitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		102 Catherine Street			
				Mrs. Minnie Cottman, Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A)				Renal Insufficiency & Failure			
ANTECEDENT CAUSE(S) DUE TO				Chronic Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Hypertension			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Oct. 3, 1955</u> to <u>Oct. 30, 1955</u>, that I last saw the deceased alive on <u>Oct. 3, 1955</u> and that death occurred at <u>9:12</u> M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
G. Herbert Lemley M.D.				Salisbury, Md. 10/15, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		11-3-55		Green Acres Memorial Park		Salisbury, Wicomico Co., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 11-2-55		Mary W. Holloman		Stewart Funeral Home		324 E. Church St. Salisbury, Md.	

1933

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

Dec 1933

Name of Deceased John V. Smith		Sex Male		Age 45	
Date of Birth Jan 15, 1888		Place of Birth Baltimore, Md.		Usual Residence 301 V. Main Street	
Cause of Death Heart of 1st		Manner of Death Natural		Occupation Salesman	
Physician's Name Dr. J. H. Jones		Hospital St. Mary's		Date of Death Nov 10, 1933	
Signature of Physician J. H. Jones		Signature of Registrar J. H. Jones		Signature of Coroner J. H. Jones	
Witnesses J. H. Jones, M.D. J. H. Jones, M.D.		Burial Place St. Mary's		Date of Burial Nov 12, 1933	
Burial Place St. Mary's		Date of Burial Nov 12, 1933		Signature of Minister J. H. Jones	
Signature of Minister J. H. Jones		Signature of Coroner J. H. Jones		Signature of Registrar J. H. Jones	

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INSTRUCTIONS

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VS A15C-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10223

CERTIFICATE OF DEATH

10228

Dr. Gilmore

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Powellville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) In Village			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
DAVID CLARENCE BAILEY				OCT. 13 th 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Aug. 29, 1876	79 yrs.	Months 1	Days 14	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josiah Bailey				14. MOTHER'S MAIDEN NAME Mary G. Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Florence Fooks Bailey (Wife) Powellville, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) Myocardial Insufficiency						1 yr.	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Heart Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) Diabetes Mellitus						Unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 4 1955 to Oct 13 1955 that I last saw the deceased alive on Oct 3 1955 and that death occurred at 2:10 P.M. from the causes and on the date stated above.							
SIGNATURE <i>David Gilmore</i>				DATE SIGNED Oct. 15 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 16, 1955		NAME OF CEMETERY OR CREMATORY St. John's Church Cemetery		LOCATION (City, town, or county) (State) Powellville, Maryland	
24. REC'D BY REGISTRAR DATE Oct. 18, 1955		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

10223 CERTIFICATE OF DEATH

10223

Name of Deceased		Place of Birth		Date of Birth	
David		Maryland		1875	
Sex		Race		Color	
Male		White		White	
Married		Single		Widow	
Cause of Death		Place of Death		Date of Death	
Heart Disease		Baltimore		1915	
Occupation		Residence		Date of Burial	
Teacher		Baltimore		1915	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

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1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

10276

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10229

CERTIFICATE OF DEATH

Dr. Quinn

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Mardela				TOWN Mardela		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		(If rural give location)	
57 Bridge Street				Bridge Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) EDWARD (Middle) STANLEY (Last) BAILEY				(Month) OCT. (Day) 4 th (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	July 11 - 1884	71 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired - Clerk		Hotel		Athol Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
T. Jefferson Bailey				Matilda Elizabeth Goslee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk				Mrs. Melvin Cobb (Daughter) Bridge St. Mardela, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Death				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary thrombosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 25 , 19 55 , to Oct 4 , 19 55 , that I last saw the deceased alive on Oct 4 , 19 55 , and that death occurred at 4:00 A M, from the causes and on the date stated above.							
SIGNATURE		M.D. Main St. Mardela, Maryland		DATE SIGNED			
Dr. Quinn				October 5 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 6, 1955		Mardela Cemetery		Mardela, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct. 7, 1955		Mary H. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

1955

STATE OF NEW YORK DEPARTMENT OF HEALTH - ALBANY, N.Y.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MRS. J. J. J.		2. SEX F		3. AGE 45	
4. PLACE OF BIRTH New York		5. DATE OF BIRTH 1910		6. PLACE OF DEATH New York	
7. OCCUPATION Housewife		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF DECEASED J. J. J.		11. SIGNATURE OF WITNESSES J. J. J. J. J.		12. SIGNATURE OF PHYSICIAN J. J. J.	
13. SIGNATURE OF CORONER J. J. J.		14. SIGNATURE OF JURY J. J. J. J. J.		15. SIGNATURE OF JURY J. J. J. J. J.	

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92. SIGNATURE OF JURY
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93. SIGNATURE OF JURY
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99. SIGNATURE OF JURY
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100. SIGNATURE OF JURY
J. J. J. J. J.

BUREAU V. 3

OCT 7 1955

RECEIVED

1

INSTRUCTIONS

1

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10230

10224

CERTIFICATE OF DEATH

Dr. Harry Mattox

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 232 Hazel Ave.			
3. NAME OF DECEASED (First) MINNIE (Middle) IVA (Last) BAKER				4. DATE OF DEATH (Month) Oct. (Day) 15th (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 11, 1887		9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR (Months) 6 (Days) 14 (Hours) Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Portsville Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Disharoon				14. MOTHER'S MAIDEN NAME Theodosia Emily Hearn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Elmer B. Baker (Husband) 232 Hazel Ave. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 420.1 Acute coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH 15 min	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery disease (occlusion)						14 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) arteriosclerosis, marked						2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/11, 1955, to 10/15, 1955, that I last saw the deceased alive on 10/15, 1955, and that death occurred at 12:30 AM, from the causes and on the date stated above.							
SIGNATURE <i>Harry Mattox</i> M.D. Camden Ave.				ADDRESS (Street, city, town, state) Salisbury, Maryland		DATE SIGNED Oct 15 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 17, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			
DATE Oct. 18, 1955							

THIS OFFICE IS THE POINT OF CONTACT FOR ALL INFORMATION RELATIVE TO THE EMIGRATION OF
 ALIENS FROM THE UNITED STATES. IT IS THE RESPONSIBILITY OF THIS OFFICE TO
 OBTAIN AND MAINTAIN A COMPLETE RECORD OF ALL ALIENS ENTERING THE
 UNITED STATES AND TO FURNISH THE NECESSARY INFORMATION TO THE
 DEPARTMENT OF STATE AND TO THE BUREAU OF IMMIGRATION AND
 NATURALIZATION.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		DATE OF DEATH	
WILLIAM J. HARRIS		OCT 18 1955	
AGE		SEX	
65		M	
RACE		RELIGION	
WHITE		METHODIST	
BIRTH DATE		BIRTH PLACE	
JAN 15 1890		BALTIMORE, MD.	
MARRIAGE DATE		MARRIAGE PLACE	
JUN 15 1915		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
EDUCATION		PLACE OF DEATH	
8 YEARS		BALTIMORE, MD.	
PREVIOUS ILLNESS		DATE OF BURIAL	
NONE		OCT 20 1955	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		W. J. HARRIS	

BUREAU V. 2

OCT 18 1955

RECEIVED

DEPARTMENT OF HEALTH - BALTIMORE, MD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10277

CERTIFICATE OF DEATH

10231

337

Dr. Lawry, Lee

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN Fruitland				TOWN Fruitland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS S. Division St Ext.				STREET ADDRESS (If rural give location) S. Division St. Ext.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) QUINTON		(Middle) GREENLEAF		(Last) BANKS		OCT. 25 th 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 8, 1981		9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR (Month) (Day) (Hours) (Min.) 7 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired) Employee of the John H. Dulany Co.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Near Fruitland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frozen & Can Foods (Gate attendant)				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Ethel Banks (Wife) S. Division St Ext. Fruitland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Central Hemorrhage						2 wks	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension						3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1952, to 10-25, 1955, that I last saw the deceased alive on 10-25, 1955, and that death occurred at 7:00P.M. from the causes and on the date stated above.							
SIGNATURE Lee L Lawry, M.D.				ADDRESS (Street, city, town, state) Fruitland, Maryland		DATE SIGNED Oct. 26 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 28, 1955		NAME OF CEMETERY OR CREMATORY Banks Family Cemetery		LOCATION (City, town, or county) Near Fruitland, Maryland	
24. REC'D BY REGISTRAR Oct. 28, 1955		REGISTRAR'S SIGNATURE Mary K. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

10331

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

REG. CH. NO.

DATE OF DEATH

WITNESSES

Physician

Physician

Physician

Division of

Division of

Division of

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BUREAU V. S.

BUREAU V. S.

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OCT 27 1933

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RECEIVED

OCT 28 1933

RECEIVED

1

INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10225

CERTIFICATE OF DEATH

10232

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>8 1/2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>427 E. Fort Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Santi</u> <u>Barranco</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 1</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/7/1874</u>		9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>- -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Salvatore Barranco</u>				14. MOTHER'S MAIDEN NAME <u>Felicia Barranco</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
177X IMMEDIATE CAUSE (A) <u>Myocardial failure</u>						<u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized carcinomatosis</u>						<u>- -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Ca. of prostate gland</u>						<u>9 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>- - - - -</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - - -</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- - - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - - - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - - - -</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- - - - -</u>			
22. I hereby certify that I attended the deceased from <u>Jan. 12</u> , 19 <u>55</u> , to <u>Oct. 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 1</u> , 19 <u>55</u> , and that death occurred at <u>10:45A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve, M.D.</u>		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital Salisbury, Maryland</u>		DATE SIGNED <u>10/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. RECEIVED BY REGISTRAR <u>Oct. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill + Johnson Co</u>		ADDRESS <u>Salisbury, Md</u> <u>Norman T. Baker</u>	

CERTIFICATE OF DEATH

1955

1955

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. TIME OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESS: [illegible]

NOTICE

BUREAU V. 2

OCT 4 1955

RECEIVED

Handwritten notes and signatures at the bottom of the page.

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10226

CERTIFICATE OF DEATH

10233

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp.</u>				STREET ADDRESS (If rural give location) <u>R.D. # 1 (Fruitland)</u>			
3. NAME OF DECEASED (Type or Print) <u>Charles Leonard Betts</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 20 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug. 18, 1874</u>	
9. AGE last birthday <u>81</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Retired Carpenter-T.W. Allen Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel H. Betts</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Wyatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Arthur L. Betts (Son) Fruitland, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
236X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hydronephrosis, Bilateral</u>				<u>12 mons</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Tumor of Bladder and Prostate</u>				<u>12 mons</u>			
19. DATE OF OPERATION <u>10-18-55</u>				19b. MAJOR FINDINGS OF OPERATION <u>marked bladder hemorrhage</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 17</u>, 19<u>55</u>, to <u>Oct. 20</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Oct. 20</u>, 19<u>55</u>, and that death occurred at <u>10:10</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Raymond M. Grew</u>				DATE SIGNED <u>10/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>Oct. 23, 1955</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary H. Holloway</u>				26. ADDRESS (Street, city, town, state) <u>Smullen Cemetery-St. Luke Near Fruitland, Maryland</u>			
27. DATE <u>Oct 24 1955</u>				28. ADDRESS <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10278

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10234

Reg. Dist.

No. 336

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
<input checked="" type="checkbox"/> TOWN <u>Delmar</u>		<u>10yrs.</u>		TOWN <u>Delmar</u> <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Foskey Lane</u>				STREET ADDRESS (If rural, give location) <u>Foskey Lane</u>			
3. NAME OF DECEASED: (First) <u>David</u>		(Middle) <u>Elliott</u>		(Last) <u>Bolen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-21-55</u> <u>19</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>July 4, 1880</u>		9. AGE last birthday: <u>75</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Wood</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME: <u>Daniel C. Bolen</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Estep</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>214-12-6579</u>		17. INFORMANT & ADDRESS: <u>Daisey Bolen, Delmar, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Ryer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-21-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10-23-1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State): <u>Salisbury, Md.</u>	
DATE REC'D BY LOCAL REG. <u>October 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Harry E. Hudson Sr</u>		24. FUNERAL DIRECTOR <u>H. S. Marmel Co. - Delmar, Del</u>		ADDRESS	

10534

10534

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

BUREAU V. S.

OCT 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10227
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10235
 Reg. Dist.
 No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MIDDLE MARYLAND		STATE <i>md</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Salisbury</i> <i>12</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Don Sea Hoop</i>				STREET ADDRESS (If rural, give location) <i>305 E. Church St</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Rebecca Marie Boyd</i>				<i>10 2 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>Col</i>	<i>Married</i>	<i>Unknown</i>	<i>23</i>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Unknown</i>		<i>Unknown</i>		<i>Unknown</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Unknown</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<i>(If Yes, give war or dates of service)</i>		<i>Unknown</i>		<i>Police Dept. City of Salisbury</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>982X Immediate cause (a) <i>Stab wound of heart</i> DUE TO</p> <p>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>Home</i>		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>Salisbury Wicomico md</i>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>10 2 55 3AM.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Stabbed by husband</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Earl L. Boyd</i>				M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER - <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <i>10-6-55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>10-6-55</i>		NAME OF CEMETERY OR CREMATORY <i>Green Boro Cem</i>		LOCATION (City, town, or county) (State) <i>Salisbury md</i>	
DATE REC'D BY LOCAL REG. <i>10-7-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. McDonay</i>		24. FUNERAL DIRECTOR <i>Broken Throat</i>		ADDRESS <i>Salisbury md</i>	

BUREAU V. S.

OCT 10 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10236

10279

CERTIFICATE OF DEATH

Dr. Larmore

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hebron				TOWN Hebron			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
Main St				Main St			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) FLAVIUS (Middle) WOODLAND (Last) BRADLEY				Oct. 14th 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	April 6, 1878	77	Months 4	Days 6	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Merchant		General Store		Columbia Delaware		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Flavius Josephus Bradley				Rachel Emily Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk				Mr. Clifford J. Bradley (Son) Hebron, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
411X IMMEDIATE CAUSE (A) _____				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/1</u> , 19 <u>54</u> , to <u>death</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/12</u> , 19 <u>55</u> , and that death occurred at <u>8A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. M. Larmore</u>				ADDRESS (Street, city, town, state) <u>M.D. Delmar Delaware</u>		DATE SIGNED <u>Oct. 15 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 16, 1955		Hebron, Cemetery		Hebron Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 18, 1955		<u>Nancy T. Holloway</u>		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

CERTIFICATE OF DEATH

Reg. Dist. No.

City and County

Age	Sex	Color	Marital Status	Occupation	Place of Birth

Date of Death	Time of Death	Place of Death	Cause of Death

Signature of Physician	Signature of Registrar	Signature of Coroner

Signature of Medical Examiner	Signature of Health Officer

Signature of Burial Director	Signature of Cemetery

Signature of Undertaker	Signature of Funeral Home

Signature of Mortician	Signature of Embalmer

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

Signature of Burial Society	Signature of Cemetery

RECEIVED
OCT 18 1955
BUREAU V. E.

EXHIBITION
BALTIMORE
MAY 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10237

10228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 Wk.</u>		TOWN <u>Eden</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Poninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>JENNIE</u>				<u>10 16 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>		8. DATE OF BIRTH <u>Jan. 1, 1881</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry Grower</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own self</u>		9. AGE last birthday <u>74</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>William H. Ware. Eden, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
199. IMMEDIATE CAUSE (A) <u>Vascular collapse.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Release of abdominal pressure - removal of ascites.</u>						<u>12 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Abdominal carcinomatosis - etiology?</u>						<u>2-3 mos.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Atherosclerosis</u>							
19a. DATE OF OPERATION <u>Oct 15, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Peritoneal implants - throat abdomen.</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10-17-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 13, 1955</u> , to <u>Oct 16, 1955</u> , that I last saw the deceased alive on <u>Oct 16, 1955</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stedman W. Smith</u>				ADDRESS (Street, city, town, state) <u>Salisbury</u>		DATE SIGNED <u>10-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/21/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		LOCATION (City, town, or county) (State) <u>Barre, Mass.</u>	
24. REC'D BY REGISTRAR <u>Oct. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u>			
				<u>Norman T. Baker</u>			

Journal of Management Education 39(6)

Winters in

video.

1

Journal of General Internal Medicine

1980-1-1000 010000

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SOLUBLE IN WATER

• *Environ Biol Fish* (2008) 81:111–120

WORM

1. *Myrica* 2. *Myrica* 3. *Myrica* 4. *Myrica* 5. *Myrica* 6. *Myrica* 7. *Myrica* 8. *Myrica* 9. *Myrica* 10. *Myrica* 11. *Myrica* 12. *Myrica* 13. *Myrica* 14. *Myrica* 15. *Myrica* 16. *Myrica* 17. *Myrica* 18. *Myrica* 19. *Myrica* 20. *Myrica* 21. *Myrica* 22. *Myrica* 23. *Myrica* 24. *Myrica* 25. *Myrica* 26. *Myrica* 27. *Myrica* 28. *Myrica* 29. *Myrica* 30. *Myrica* 31. *Myrica* 32. *Myrica* 33. *Myrica* 34. *Myrica* 35. *Myrica* 36. *Myrica* 37. *Myrica* 38. *Myrica* 39. *Myrica* 40. *Myrica* 41. *Myrica* 42. *Myrica* 43. *Myrica* 44. *Myrica* 45. *Myrica* 46. *Myrica* 47. *Myrica* 48. *Myrica* 49. *Myrica* 50. *Myrica* 51. *Myrica* 52. *Myrica* 53. *Myrica* 54. *Myrica* 55. *Myrica* 56. *Myrica* 57. *Myrica* 58. *Myrica* 59. *Myrica* 60. *Myrica* 61. *Myrica* 62. *Myrica* 63. *Myrica* 64. *Myrica* 65. *Myrica* 66. *Myrica* 67. *Myrica* 68. *Myrica* 69. *Myrica* 70. *Myrica* 71. *Myrica* 72. *Myrica* 73. *Myrica* 74. *Myrica* 75. *Myrica* 76. *Myrica* 77. *Myrica* 78. *Myrica* 79. *Myrica* 80. *Myrica* 81. *Myrica* 82. *Myrica* 83. *Myrica* 84. *Myrica* 85. *Myrica* 86. *Myrica* 87. *Myrica* 88. *Myrica* 89. *Myrica* 90. *Myrica* 91. *Myrica* 92. *Myrica* 93. *Myrica* 94. *Myrica* 95. *Myrica* 96. *Myrica* 97. *Myrica* 98. *Myrica* 99. *Myrica* 100. *Myrica*

1. The first group of people who are not in the labor force are those who are not in the labor force for any reason. This group is the largest and is made up of people who are not in the labor force for any reason. This group is the largest and is made up of people who are not in the labor force for any reason.

BUREAU V. 8

OCT 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10238

10229

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		TOWN <u>Wenona</u>	<u>19X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>82 Peninsula General Hospital</u>			
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Joseph Brummitt</u>		<u>Oct. 23, 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>		<u>10-23-53</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
yrs. Months Days		8 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>James Brummitt</u>		<u>Norma Lee Parkinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes</u>		<u>-</u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>Mrs Beulah Parkinson</u>		<u>Wenona</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>761.5 IMMEDIATE CAUSE (A) Prematurity</u>			
<u>ANTECEDENT CAUSE(S) DUE TO</u>			
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>			
<u>STATING UNDERLYING CAUSE LAST.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Placenta Praevia + Cesarean Section</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>Morris C. Lambdin</u>		<u>707 Camden Ave Salisbury Md.</u>	
DATE		DATE SIGNED	
<u>10-24-55</u>		<u>10/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR	
<u>10-24-55</u>		<u>Mary W. Holloway</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>L. G. Webster, Ideal Island</u>			

2005282281

THIS IS A PRELIMINARY REPORT OF THE RESULTS OF THE INVESTIGATION OF THE DEATH OF THE ABOVE NAMED PERSON. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE BUREAU OF HEALTH AND SHALL BE RETURNED TO THE BUREAU OF HEALTH UPON REQUEST.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10-10810-1

REG. ONE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

BUREAU V. S.

OCT 28 1955

RECEIVED

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10230

CERTIFICATE OF DEATH

10239

Reg. Dist. No. 322

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury, Maryland</u>		<u>32 days</u>		TOWN <u>Baltimore, Maryland</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>620 St. Anns Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Kate</u>		(Middle) <u>Mary</u>		(Last) <u>Buckley</u>		(Month) <u>Oct.</u> (Day) <u>2</u> (Year) <u>1955</u>	
5. SEX	6. COLOR OR	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>April 17, 1882</u>		<u>73</u> yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>None</u>			<u>None</u>		<u>Ireland</u>		<u>unk</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Barrett</u>				<u>Catherine O'Connell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk</u>		<u>unk</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>332X</u>						<u>Cerebral Thrombosis</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis Gen.</u>						<u>7 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 31</u> , 19 <u>55</u> , to <u>Oct. 2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 2</u> , 19 <u>55</u> , and that death occurred at <u>10:30A</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. H. Halloway</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>10/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/5/55</u>		<u>St. Peters Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 3, 1955</u>		<u>Mary H. Halloway</u>		<u>Wm. Cook Inc.</u>		<u>1217 St. Paul Street</u>	

CERTIFICATE OF DEATH

1955

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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BUREAU V. 3

OCT 4 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10231

CERTIFICATE OF DEATH

10240

Item 12, Film 187 10-17-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		5 yrs.		TOWN <u>Elkton</u>		07x.2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. # 3</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John C. Clemmings</u>				<u>Oct. 7 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 11, 1860</u>	9. AGE last birthday <u>95</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>- -</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Clemmings</u>				14. MOTHER'S MAIDEN NAME <u>Jane Browning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-28-2762A</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151x IMMEDIATE CAUSE (A) <u>Cerebral embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Carcinoma</u>						4 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Carcinoma of stomach</u>						2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Ununited fracture of left hip</u>						7 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 20, 19 50</u> , to <u>Oct. 7, 19 55</u> , that I last saw the deceased alive on <u>Oct. 7, 19 55</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Juerman</u> V. Juerman, M.D.				DATE SIGNED <u>10/7/55</u>			
				ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/11/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
24. REC'D BY REGISTRAR <u>Mary H. Hallways</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pyper Funeral Home</u>		ADDRESS <u>Elkton, Md.</u>	
DATE <u>Oct. 14, 1955</u>							

10840

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form No. 10-1

STATE OF MARYLAND - DEPARTMENT OF HEALTH

DATE OF DEATH

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

IN MEDICAL CERTIFICATE

IN MEDICAL CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

BUREAU V. M.

OCT 14 1955

RECEIVED

NOTIFICATION
The undersigned hereby certifies that the above is a true and correct copy of the original as the same appears in the files of the Department of Health, State of Maryland, at Baltimore, Maryland, this 14th day of October, 1955.
J. M. SMITH, Jr.
Assistant Secretary

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10241

Reg. Dist.

No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury, Md.
 TOWN Salisbury, Md.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Virginia COUNTY Accomack
 CITY (If outside corporate limits write RURAL and give nearest town) Wattsville, Va.
 TOWN Wattsville, Va.
 STREET ADDRESS (If rural, give location) 83X-3

3. NAME OF DECEASED: (First) (Middle) (Last)
Edith Rhodes Conquest
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
Oct. 1 19 55

5. SEX: F. 6. COLOR OR RACE: C. 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married 8. DATE OF BIRTH: 4/25/1922 9. AGE last birthday: 33 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): house wife 10b. KIND OF BUSINESS OR INDUSTRY: Virginia 11. BIRTHPLACE (State or foreign country): U.S.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Estee Johnson

14. MOTHER'S MAIDEN NAME:

Ida Conner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY No.:

219-07-6393

17. INFORMANT & ADDRESS:

Ida Johnson, Wattsville, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

916.0
 Immediate cause (a) Septicemia
 DUE TO
 Antecedent cause(s) (b) second and third degree burns—80 % body surface.
 Diseases or conditions, if any, giving rise to the above cause DUE TO
 stating underlying cause last (c) 12 days...

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home 21c. (City or town) (County) (State) Wattsville Accomack Virginia.
 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 9 20 55 M. 21e. INJURY OCCURRED While at work ☐ Not while at work ☒ 21f. HOW DID INJURY OCCUR? Burning trash and caught clothes afire.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Earl RyeCHIEF MEDICAL EXAMINER ☒ DATE SIGNEDDEPUTY MEDICAL EXAMINER ☐M. D. ASSISTANT MEDICAL EXAM. ☐ 10-3-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF 10/3/55 NAME OF CEMETERY OR CREMATORY Wattsville, Cem. LOCATION (City, town, or county) (State) Wattsville, Va.

DATE REC'D BY LOCAL

10-4-55

REGISTRAR'S SIGNATURE

Mary M. Holloway

24. FUNERAL DIRECTOR

Edgar Webster

ADDRESS

new church, 24

BUREAU V. 5

OCT 6 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10233

CERTIFICATE OF DEATH

10242

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>923 Brown St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Crockett</u>				<u>October 6 1953</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Male</u>	<u>White</u>	<u>None</u>	<u>None</u>	<u>44</u>	<u>4</u> <u>15</u>	<u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Winifred Benjamin Crockett</u>				<u>Catherine Reba Bramble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>None</u>		<u>None</u>		<u>Mother & Father</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
762.5 IMMEDIATE CAUSE (A)						<u>Erythroblastosis</u>	
ANTECEDENT CAUSE(S) DUE TO						<u>Distocytosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)						<u>Prematurity & Anemia</u>	
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/6/53</u> , 19 <u>53</u> , to <u>10/6/53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>10/6/53</u> , 19 <u>53</u> , and that death occurred at <u>7:13</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Wm. B. Smith</u>				DATE SIGNED <u>10/8/53</u>			
23. DATE CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>10/8/53</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10-7-53</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10243

10234

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>8 days</u>		TOWN <u>Powellville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 PENINSULA GENERAL Hospital</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lizzie</u> (First) <u>DAVIS</u> (Last)				<u>October 21</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>FEMALE</u>	<u>white</u>		<u>Aug. 3, 1876</u>	<u>79</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaac Smith</u>				<u>Sarah Truitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. Maggie Timmons, Powellville</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				<u>Exacerbated C. V. Disease</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Early gangrene of foot</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>Yes</u>			
				<u>3 weeks</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-11</u> , 19 <u>55</u> , to <u>10-21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-21</u> , 19 <u>55</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. B. Brule</u>		M.D. <u>226 W. Division St</u>		ADDRESS (Street, city, town, state) <u>Powellville, Md</u>		DATE SIGNED <u>10-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>10-23-55</u>		<u>Truitt Cemetery</u>		<u>Powellville, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-23-55</u>		<u>Mary W. Holloway</u>		<u>Peter Whaley</u>		<u>Selbyville, Del.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10244

10235

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>22 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>926 E. Church St.</u>				STREET ADDRESS (If rural give location) <u>926 E. Church St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Gertha Gertrude Dennis</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>Oct. 3, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE. MARRIED. <u>Married</u>		8. DATE OF BIRTH: <u>April 23, 1879</u>	
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Clifford S. Dennis</u>				14. MOTHER'S MAIDEN NAME: <u>Miss Nettie L. Dennis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Mrs. Helen Hancock Salisbury</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>							
ANTECEDENT CAUSE (B) <u>Asthma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Hypertrophic Atherosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>10-18-55</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-18-54</u> , 19 <u>54</u> , to <u>10-3-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-21-55</u> , 19 <u>55</u> , and that death occurred at <u>2:45 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Andrew C. Mitchell</u>				ADDRESS <u>2151 M. D. Salisbury, Md.</u>		DATE SIGNED <u>10/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 5 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-5-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR ADDRESS <u>Peter Whaley Salisbury, Del.</u>			

BUREAU V. S.

OCT 10 1955

RECEIVED

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10245

10236

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Pocomoke</u>		<u>23-42-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Harry</u> (Middle) <u>Downs</u> (Last) <u>Downs</u>				<u>October 5 - 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>W</u>		<u>3</u>	<u>34</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>?</u>		<u>?</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>?</u>		<u>Ben Sen 102p</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422.2 Pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive heart failure</u>				<u>6 mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>degenerative heart disease</u>				<u>2 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic myeloid leukemia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 35</u> , 19 <u>55</u> , to <u>Oct. 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>55</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>10-5-55</u>	
M.D. <u>Salisbury Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Oct 7 1955</u>		<u>Cenatoma Rd Baltimore</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct. 10, 1955</u>		<u>Mary J. Hallaway</u>		<u>Ben Sen</u>			

10845

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL HEALTH OFFICE OF RECORD

DATE OF DEATH

DECEASED

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

US BORN

ALIEN

DATE OF ARRIVAL

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. 2

OCT 10 1959

RECEIVED

EXHIBITION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 1076

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10280

CERTIFICATE OF DEATH

10246

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Bivalve</i>		<i>Lifetime</i>		TOWN <i>Bivalve</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Oscar S. Dunn</i>				<i>10-18-55</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>8/30/1871</i>		9. AGE last birthday <i>84</i> yrs.	10. IF UNDER 1 YEAR <i>1</i> month <i>18</i> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Bivalve, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Columbus Dunn</i>				14. MOTHER'S MAIDEN NAME <i>Hennietta Anderson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-30-1499</i>		17. INFORMANT & ADDRESS <i>Sula Dunn, Bivalve, Maryland</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Vascular Neurology</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized Arteriosclerosis</i>				<i>10 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Inattention</i>				<i>1 week</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>19 July, 1947</i> to <i>18 Oct, 1955</i> that I last saw the deceased alive on <i>18 Oct, 1955</i> and that death occurred at <i>1025 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Delbert H. Saunders</i> M.D.				ADDRESS (Street, city, town, state) <i>Nantuxet Rd. Bivalve, Md.</i>		DATE SIGNED <i>10/19/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10/22/55</i>		NAME OF CEMETERY OR CREMATORY <i>Bivalve Cem.</i>		LOCATION (City, town, or county) (State) <i>Bivalve, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>C. S. Mesnick</i>		ADDRESS <i>Bivalve, Md.</i>	
DATE <i>OCT 24 1955</i>							

BUREAU V. S.

OCT 24 1955

RECEIVED

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72** hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10237

CERTIFICATE OF DEATH

10247

Dr. Beardsley

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Parsonsborg		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riverside Convalescent Home				STREET ADDRESS (If rural give location) In Village			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
IRENE STILES EMERSON				Oct. 29th 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	Nov. 21, 1887	67 yrs.	11 Months 8 Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		at Home		Mt. Vernon New York		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Noble Glover				Jessie Irene Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mr. Frank N. Glover (Brother) Parsonsborg Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 199.1 Adenocarcinoma of origin				INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 29 1955 12:45 PM to Oct 29 1955 12:45 PM that I last saw the deceased alive on Oct 29 1955 and that death occurred at 12:45 PM from the causes and on the date stated above.							
SIGNATURE Dr. Beardsley				DATE SIGNED Oct. 29 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				24. REC'D BY REGISTRAR Nov. 1, 1955			
DATE THEREOF Nov. 1, 1955				NAME OF CEMETERY OR CREMATORY Rowayton Cemetery			
25. FUNERAL DIRECTOR'S SIGNATURE Mary H. Holloway				ADDRESS Rowayton, Conn.			
26. REGISTRAR'S SIGNATURE Mary H. Holloway				27. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
DATE OCT 31 1955				ADDRESS SALISBURY MARYLAND			

PHOTOGRAPH

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CERTIFICATE OF DEATH

1953

Name of Deceased Frank Louis Kline		Date of Birth Nov. 21, 1907		Sex Male		Race White		Marital Status Married		Place of Birth New York	
Cause of Death Heart Disease		Date of Death Oct. 27, 1953		Place of Death New York		Occupation Teacher		Education High School		Religion Roman Catholic	
Signature of Physician J. Edgar Hoover		Signature of Registrar J. Edgar Hoover		Signature of Informant J. Edgar Hoover		Signature of Coroner J. Edgar Hoover		Signature of Burial Officer J. Edgar Hoover		Signature of Funeral Home J. Edgar Hoover	
Date of Report Oct. 27, 1953		Place of Report New York		Occupation of Informant Teacher		Education of Informant High School		Religion of Informant Roman Catholic		Signature of Informant J. Edgar Hoover	

BUREAU OF INVESTIGATION

OCT 31 1953

RECEIVED

U.S. DEPARTMENT OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10238

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10248

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
12 TOWN Salisbury		All life		TOWN Salisbury 12			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
At home - 346 Delaware Ave.				346 Delaware Avenue 1			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH		(Month) (Day) (Year)	
(First) Ada (Middle) Elizabeth (Last) Ennis				10 19		1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		A.A.		Married		3-25-1920	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
35 yrs.		6		4		1955	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Elevator Oper.				Benjamins Store		Salisbury, Wicomico Co. Md.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
USA				Unknown			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			
Cora Wallace				No			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
Yes - lost				336 Catherine Street			
				Mrs. Margaret Hall, Salisbury, Maryland			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
981X Immediate cause (a) Shotgun wound of brain Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						10	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>				21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			
				21b. PLACE (Home, farm, factory, street, office bldg., etc.) Home			
				21c. City (town) (County) (State) Salisbury Wicomico Md			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 19 55 732				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				21f. HOW DID INJURY OCCUR? Shot by husband			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul L. Rye				M. D. 10-22-55			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial				DATE THEREOF 10-23-55			
NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park				LOCATION (City, town, or county) (State) Salisbury, Wicomico Co., Md.			
DATE REC'D BY LOCAL REG 12-24-55				REGISTRAR'S SIGNATURE Mary W. Hollonay			
24. FUNERAL DIRECTOR Mary A. Stewart				324 E. Church St. ADDRESS Salisbury, Maryland			

BUREAU V. 2

RECEIVED
OCT 28 1942

10-17-42 Green Arrow Memorial Park Salisbury, Maryland Co. No. 100

355 Catherine Street
Dover Delaware

Yes - 1000 Mrs. Margaret Hall, Salisbury, Maryland

Unknown

No

Marion Green, Baltimore, Md.

Salisbury, Maryland Co. No. 100

Female

Married

10-17-42

35

4

355 Delaware Avenue

45 Home - 355 Delaware Ave.

Salisbury

10-17-42

Salisbury

Wisconsin

Kentwood, Wisconsin

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10249

10281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hebron</u>		<u>25 Yrs.</u>		TOWN <u>Hebron</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt #1</u>				STREET ADDRESS (If rural give location) <u>Rt #1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Stephen</u> (Middle) <u>Filmore</u> (Last) <u>Evans</u>				(Month) <u>10</u> (Day) <u>13</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 15, 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>Partner</u>)			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Millard F. Evans</u>				14. MOTHER'S MAIDEN NAME <u>Henriettie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Levin Evans, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 19 55</u> , to <u>Oct. 13, 19 55</u> , that I last saw the deceased alive on <u>Oct. 7, 19 55</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John Swann Jr.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Baker</u> ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>			

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10250

10239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>4 yrs. 2 mos.</u>		TOWN <u>Baltimore</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>1334 N. Eden Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Rosy Frey</u>				<u>Oct. 29 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>Mar. 25, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unk.</u>		<u>Unk.</u>		<u>Baltimore, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alfred Gibson</u>				<u>Florence Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>593X</u> IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Inter-capillary Glomerulonephritis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>2608</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>18 years</u>	
<u>Diabetes, mellitus</u>						<u>Bilateral femoral amputation - 4 mos. 2 wks.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 28, 1951</u> to <u>Oct. 29, 1955</u> that I last saw the deceased <u>alive on</u> <u>Oct. 29, 1955</u> and that death occurred at <u>11:25A</u> from the causes and on the date stated above.							
SIGNATURE <u>J. B. Maloney</u>				ADDRESS (Street, city, town, state) <u>Balto. Md.</u>			
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/30/55</u>		<u>Mt. Calvary</u>		<u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct 31 1955</u>		<u>Mary H. Holloway</u>		<u>Chas. W. Wilson</u>		<u>100 Brantly St</u>	
DATE							

10530

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERIODIC EXAMINATION

DATE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF HOSPITAL

NAME OF NURSE

NAME OF ATTENDING PHYSICIAN

NAME OF ASSISTANT PHYSICIAN

NAME OF PATHOLOGIST

NAME OF ANATOMIST

NAME OF RADIOLOGIST

NAME OF CLINICAL PATHOLOGIST

NAME OF CLINICAL CHEMIST

NAME OF CLINICAL MICROSCOPIC

NAME OF CLINICAL BACTERIOLOGIST

NAME OF CLINICAL PHARMACOLOGIST

NAME OF CLINICAL TOXICOLOGIST

NAME OF CLINICAL IMMUNOLOGIST

NAME OF CLINICAL NEUROLOGIST

NAME OF CLINICAL PSYCHIATRIST

NAME OF CLINICAL RADIOLOGIST

NAME OF CLINICAL PHYSICIAN

NAME OF CLINICAL NURSE

NAME OF CLINICAL LABORATORY

NAME OF CLINICAL RESEARCH

NAME OF CLINICAL TEACHING

NAME OF CLINICAL STUDY

NAME OF CLINICAL PRACTICE

NAME OF CLINICAL SERVICE

NAME OF CLINICAL DEPARTMENT

NAME OF CLINICAL DIVISION

NAME OF CLINICAL SECTION

NAME OF CLINICAL BRANCH

NAME OF CLINICAL UNIT

NAME OF CLINICAL TEAM

NAME OF CLINICAL GROUP

NAME OF CLINICAL SOCIETY

NAME OF CLINICAL ASSOCIATION

NAME OF CLINICAL CONFERENCE

BUREAU V. E.

1955

RECEIVED

SIGNATURE

DATE

TIME

PLACE

STATE

CITY

COUNTY

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10240

CERTIFICATE OF DEATH

10251

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury, Maryland</u>		LENGTH OF STAY (in this place) <u>285 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>		<u>09-13-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>324 Pine Street</u>		✓	
3. NAME OF DECEASED (Type or Print) <u>John Henry Gladden</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 29 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>April 15, 1879</u>	
9. AGE last birthday <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Fred Gladden</u>				14. MOTHER'S MAIDEN NAME <u>Lettie Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>027X</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Lues, treated</u>				?			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 17, 1955</u> , to <u>Oct. 29, 1955</u> , that I last saw the deceased alive on <u>Oct. 28, 1955</u> , and that death occurred at <u>5:30A</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>J. V. Malcher</u>				ADDRESS (Street, city, town, state) <u>Cambridge, Md.</u>			
DATE SIGNED <u>11/3/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 1 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. S. Clark Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	

10282

10252
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>White Haven</u>		<u>life</u>		TOWN <u>Tyaskin</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>White Haven Road</u>				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Shelley Leroy Handy</u>				<u>10-29-1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>O</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Dec: 7, 1911</u>	9. AGE last birthday: <u>44</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Oyster Longing</u>		11. BIRTHPLACE (State or foreign country): <u>Tyaskin, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Carv Handy</u>				14. MOTHER'S MAIDEN NAME: <u>Julia Conway</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Nellie Handy, Tyaskin, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Sudden	
<u>823X</u> Immediate cause (a) <u>Crushed skull</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) (County) (State)		<u>White Haven Wicomico Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10-29-55 6:30AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car went out of control and ran off road.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-31-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>11/1/55</u>		NAME OF CEMETERY OR CREMATORY: <u>New Town Cemetery</u>		LOCATION (City, town, or county) (State): <u>Tyaskin Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-3-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloray</u>		24. FUNERAL DIRECTOR: <u>C. T. Messick</u>		ADDRESS: <u>Bivalve, Md.</u>	

BUREAU V. S.

NOV 2 1955

RECEIVED

10241

CERTIFICATE OF DEATH

Reg. Dist. No.

337

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Summit</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 <u>Salisbury</u>		4 <u>hrs.</u>		11 <u>Salisbury</u> <u>Del.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
81 <u>Peninsula General Hospital</u>				46 <u>X-3</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Carrie</u> (Middle) <u>Hazel</u> (Last)				OF DEATH: <u>10-31-1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>1877-9-8</u>	
9. AGE last birthday <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House work.</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA.</u>	
13. FATHER'S NAME: <u>John Hudson</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret H.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>John Hazel Salisbury Del.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>						<u>unknown</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of uterus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>10/27/1955</u> , to <u>10/31/1955</u> that I last saw the deceased alive on <u>10/27/1955</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		ADDRESS <u>Salisbury, Md.</u>		DATE SIGNED <u>11-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-3-55</u>		<u>First Hill Cemetery</u>		<u>Philadelphia Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-2-55</u>		REGISTRAR'S SIGNATURE <u>Walter H. Bursey</u>		24. FUNERAL DIRECTOR <u>Watson & Gray</u>		ADDRESS <u>Frederick, Del.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 51

NOV 4 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10254

10242

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (In this place) 2 wks.		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital		STREET ADDRESS (If rural give location) 320 Poplar Hill Ave.,					
3. NAME OF DECEASED (First) (Middle) (Last) MILDRED HIGGINS				4. DATE OF DEATH (Month) (Day) (Year) 10 3 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH April 29, 1899	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leonard H. Higgins				14. MOTHER'S MAIDEN NAME Annabel Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) No.		16. SOCIAL SECURITY NO. 067-26-4466		17. INFORMANT & ADDRESS Mrs. J. M. McGrath /Same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1 IMMEDIATE CAUSE (A) 422.2 <i>Chronic myocarditis - aortic insufficiency</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Acute cardiac decompensation</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-25 , 19 55 , to 10-3 , 19 55 , that I last saw the deceased alive on 10-3 , 19 55 , and that death occurred at 5:20 AM , from the causes and on the date stated above.							
SIGNATURE <i>Paul G. Taylor</i>				ADDRESS (Street, city, town, state) Salisbury, Md		DATE SIGNED 10-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/5/1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR Oct-6, 1955		REGISTRAR'S SIGNATURE <i>Mary D. Hallaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE 1 The Hill & Johnson Co., Salisbury, Md.			

00100000

2003

▼ **NEW**

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1944

Estadística de la producción agropecuaria

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TABLE 1

1945-1946

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1992

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BUREAU V. S.

OCT 6 1955

RECEIVED

[illegible]

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• The Hill & Johnson Co., Salisbury, Md.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10283

CERTIFICATE OF DEATH

11371

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN Delmar		LENGTH OF STAY (in this place) 71 yrs		CITY OR TOWN Delmar			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 406 Chestnut Street				STREET ADDRESS (If rural give location) 406 Chestnut Street			
3. NAME OF DECEASED (Type or Print) Seenary Ethel Hitchens				4. DATE OF DEATH Oct. 31 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE MARRIED, WIDOWED Married (Specify)		8. DATE OF BIRTH Aug. 24, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		9. AGE last birthday 71 yrs.		11. BIRTHPLACE (State or foreign country) Delmar, Md.	
13. FATHER'S NAME Benjamin Truitt				14. MOTHER'S MAIDEN NAME Ellen Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Edward L. Hitchens, Delmar, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Coronary occlusion, acute						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSE(S) DUE TO (B) coronary and generalized arteriosclerosis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) hypertension, essential severe						10 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953 , to Oct 31 , 19 55 , that I last saw the deceased alive on Oct 31 , 19 55 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
SIGNATURE [Signature]		M. D. Delmar, Md.		DATE SIGNED Nov. 1, 55			
23. BURIAL CREMATION, REINTERMENT (SPECIFY) Burial		DATE THEREOF 11-2-55		NAME OF CEMETERY OR CREMATORY Mt Olive		LOCATION (City, town, or county) (State) Delmar, Delaware	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Md.		ADDRESS	

CERTIFICATE OF DEATH

1923

Reg. Dist. No.

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of undertaker

7. Name of funeral home

8. Name of cemetery

9. Name of burial place

10. Name of interment

11. Name of funeral home

12. Name of cemetery

13. Name of burial place

14. Name of interment

15. Name of funeral home

16. Name of cemetery

17. Name of burial place

18. Name of interment

19. Name of funeral home

20. Name of cemetery

21. Name of burial place

22. Name of interment

23. Name of funeral home

24. Name of cemetery

25. Name of burial place

26. Name of interment

27. Name of funeral home

28. Name of cemetery

29. Name of burial place

30. Name of interment

31. Name of funeral home

32. Name of cemetery

33. Name of burial place

34. Name of interment

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of undertaker

7. Name of funeral home

8. Name of cemetery

9. Name of burial place

10. Name of interment

11. Name of funeral home

12. Name of cemetery

13. Name of burial place

14. Name of interment

15. Name of funeral home

16. Name of cemetery

17. Name of burial place

18. Name of interment

19. Name of funeral home

20. Name of cemetery

21. Name of burial place

22. Name of interment

23. Name of funeral home

24. Name of cemetery

25. Name of burial place

26. Name of interment

27. Name of funeral home

28. Name of cemetery

29. Name of burial place

30. Name of interment

31. Name of funeral home

32. Name of cemetery

33. Name of burial place

34. Name of interment

BUREAU V. E.

NOV 15 1923

RECEIVED

STATE OF MARYLAND - BALTIMORE

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Name of physician

6. Name of undertaker

7. Name of funeral home

8. Name of cemetery

9. Name of burial place

10. Name of interment

11. Name of funeral home

12. Name of cemetery

13. Name of burial place

14. Name of interment

15. Name of funeral home

16. Name of cemetery

17. Name of burial place

18. Name of interment

19. Name of funeral home

20. Name of cemetery

21. Name of burial place

22. Name of interment

23. Name of funeral home

24. Name of cemetery

25. Name of burial place

26. Name of interment

27. Name of funeral home

28. Name of cemetery

29. Name of burial place

30. Name of interment

31. Name of funeral home

32. Name of cemetery

33. Name of burial place

34. Name of interment

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10255

10243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (in this place) 2 Mons		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Spring Hill Pr. Sani.				STREET ADDRESS (If rural give location) 312 New York Ave.,		12	
3. NAME OF DECEASED (Type or Print) IDA MARIA HOLLAND				4. DATE OF DEATH (Month) (Day) (Year) 10 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 29, 1864	9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kendall Massey				14. MOTHER'S MAIDEN NAME Gertrude Gordy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS W. Tracey Holland, Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 420.1						Coronary Thrombosis	
ANTECEDENT CAUSE(S) DUE TO (B) 190.9						Atherosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Fracture left femur	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 16, 1953, to Oct. 19, 1955, that I last saw the deceased alive on Oct. 19, 1955, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Smith M.D.</i>				ADDRESS (Street, city, town, state) <i>Salisbury, Md. 10-17-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/21/1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE <i>Oct. 21, 1955</i>		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>George C. Hill</i>			
				ADDRESS The Hill & Johnson Co. Salisbury, Md			

10554

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED

John J. Jones

DATE OF DEATH

21 Nov 1935

PLACE OF DEATH

Baltimore

RESIDENCE OF DECEASED

Baltimore

112 New York Ave.

John J. Jones, Sr.

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Maryland

John J. Jones

John J. Jones

George Jones

Samuel Jones

John J. Jones, Sr.

John

John

BUREAU V. S.

OCT 21 1935

RECEIVED

Baltimore

Baltimore

10/21/35

The Hall & Johnson Co. Baltimore, Md.

RECEIVED

RECEIVED
OCT 21 1935
BUREAU V. S.
RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10244

CERTIFICATE OF DEATH

10256

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 Day</u>		CITY OR TOWN <u>Quantico</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>HURSCHEL THOMAS HOPKINS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 14 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 24, 1907</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Attended</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>185-10-2359</u>		17. INFORMANT & ADDRESS <u>Mrs. H.T. Hopkins, same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Artery Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u>				<u>9 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Prior yamul Auricular Tachycardia</u>				<u>73</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 48</u> , 19 <u>48</u> , to <u>Oct. 14</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Oct. 14</u> , 19 <u>55</u> and that death occurred at <u>11:33</u> M., from the causes and on the date stated above.							
SIGNATURE <u>David L. Silvers</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Oct. 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grange Cemetery</u>		LOCATION (City, town, or county) <u>Chesapeake, Maryland</u> (State) <u>MD</u>	
24. REC'D BY REGISTRAR <u>Oct 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Bellows</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u> ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>			

CERTIFICATE OF DEATH

1. NAME OF DEATH
2. SEX
3. AGE
4. OCCUPATION
5. PLACE OF BIRTH
6. DATE OF BIRTH
7. PLACE OF DEATH
8. DATE OF DEATH
9. CAUSE OF DEATH
10. MANNER OF DEATH
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS
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BUREAU V. S.

OCT 18 1925

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NOTICE

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10245

CERTIFICATE OF DEATH

10257

237

Dr. Gardner

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen Hospital				STREET ADDRESS (If rural give location) 1009 Phillips Ave.			
3. NAME OF DECEASED (Type or Print) WILLIAM WALLACE HORSEY				4. DATE OF DEATH (Month) Oct. (Day) 9 th (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 29, 1895	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months 8 Days 10	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Household items		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Horsey				14. MOTHER'S MAIDEN NAME Emma Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Mary W. Horsey (Wife) 1009 Phillips Ave. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) CORONARY OCCLUSION, R+L+EFF. CORONARY ARTERIES				INTERVAL BETWEEN ONSET AND DEATH 3 mos + 3 d			
ANTECEDENT CAUSE(S) (B) Thrombosis				3 d AS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) ARTERIO SCLEROTIC CARDIOVASCULAR DS				(?)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB. , 19 55 , to OCT 9 , 19 55 , that I last saw the deceased alive on 10/9 , 19 55 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above.							
SIGNATURE <i>Robert S. Gardner Jr.</i>				ADDRESS (Street, city, town, state) DATE SIGNED M.D. 321 S. Division St Salisbury, Md. Oct. 10 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 12, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE Oct. 14, 1955		REGISTRAR'S SIGNATURE <i>Mary St. Hallaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

• *NOTES* •

2010

1994

BUREAU V. 8.

OCT 11 1965

1. 1. The first part of the paper

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10246				10258			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Accomack</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		33X-21	
TOWN <u>Salesbury</u>		<u>3 days</u>		TOWN <u>Bishop</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pennsauken General</u>				STREET ADDRESS (If rural, give location) <u>1 Rural - Route 113</u>			
3. NAME OF DECEASED:		(First) <u>Sarah</u>		(Middle) <u>M.</u>		(Last) <u>Hudson</u>	
(Type or Print)				4. DATE OF DEATH		10 28 19 45	
5. SEX: <u>2</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>Mar. 6, 1886</u>	
				9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Samuel Duke</u>				14. MOTHER'S MAIDEN NAME: <u>Lena Murray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Martha Bunting Bishop, Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION			
825X Immediate cause				Interval BETWEEN ONSET AND DEATH <u>less than 3 days</u>			
Antecedent cause(s)				DUE TO <u>Concussion of Brain, Cerebral Accidents, fractures of pelvis, left radius, lateralization of face, etc.</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last				DUE TO <u>Auto. accident</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, place bldg., etc.) OF INJURY: <u>Highway</u>		21c. (City or town) (County) (State) <u>Bishop Worcester Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Oct 25 33 4:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>23</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>N.E. Sartorius</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/28/53</u>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <u>Henry W. Watson, Pocomoke City, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10/30/53</u>		NAME OF CEMETERY OR CREMATORY: <u>Odd Fellows</u>		LOCATION (City, town, or county) (State): <u>Bishop, Worcester, Md</u>	
DATE REC'D BY LOCAL REG. <u>11-1-53</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Henry W. Watson</u>		ADDRESS: <u>Pocomoke City, Md.</u>	

RECEIVED

NOV 3 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10259

10247

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 Peninsula General Hospital</u>				<u>West road # 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>Male</u>		<u>Colored</u>		<u>JACKSON</u>		<u>October 29-1955</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Colored</u>		<u>Single</u>		<u>October 29-1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
						<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Nathaniel Jackson</u>				<u>Mary Lee Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Mary Lee Jackson + Nathaniel Jackson</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1762.5 IMMEDIATE CAUSE (A) <u>atelectasis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>10/29/55</u>		<u>atelectasis</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/29/55</u> , to <u>10/29/55</u> , that I last saw the deceased alive on <u>10/29/55</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>William C. Morgan M.D.</u>				<u>Salisbury Md</u>			
DATE <u>10/29/55</u>				DATE SIGNED <u>10/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>cremation</u>		<u>10/31/55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>10-31-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>		<u>Salisbury Md</u>	
<u>2005246991</u>							

10523

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

10517

First Time

NAME OF DECEASED

MARYLAND

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STATE
COUNTY

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BUREAU V. S.

NOV 2 1955

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UNCLASSIFIED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10284				10260			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>California</u> COUNTY <u>SAN Diego</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Hebron</u>		<u>10 months</u>		TOWN <u>SAN Diego</u>		<u>43X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>4557 West Talmadge Drive</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
		<u>Donald</u>		<u>Gordon</u>		<u>Tackson</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>M</u>		<u>W</u>		<u>MARRIED</u>		<u>5-17-21</u>	
						9. AGE last birthday: <u>34</u> yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Pilot-USN</u>	
						11. BIRTHPLACE (State or foreign country): <u>California</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles B. Jackson</u>				<u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>yes</u>				<u>6-2-43 TO DATE</u>		<u>U.S. Navy Official Records</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>860X Crushed Skull</u>						<u>Sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
		<u>Home</u>		<u>Hebron Wicomico Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 6 55 732</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Plane Crash - mid air collision</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. L. Rye</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
DATE REC'D BY LOCAL REG. <u>10-10-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		24. FUNERAL DIRECTOR <u>P. B. Robinson - Leonardtown, Md</u>		ADDRESS	

1935

1935

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE MINT

FOR THE YEAR 1935

1935 RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE MINT

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BUREAU V. S.

OCT 11 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH: 10248		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital		STREET ADDRESS (If rural, give location) 406 Hammond St.	
3. NAME OF DECEASED: (First) EARL (Middle) WALTON (Last) JERMAN		4. DATE OF DEATH (Month) Oct. (Day) 6 (Year) 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Oct. 9, 1908
9. AGE last birthday: 46 yrs.		10. BIRTHPLACE (State or foreign country): Willards, Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Salesman Furniture Co.		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: George H. Jerman		14. MOTHER'S MAIDEN NAME: Lula V. Downs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: Mrs. Mattie J. Jerman (Wife) 406 Hammond St. Salisbury, Maryland	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 976 X Bullet Wound of Brain		
Immediate cause (a) DUE TO		
Antecedent cause(s) (b) DUE TO		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY 10-6-55 6:35 M.
21c. (City or town) Salisbury (County) Wicomico (State) MD	21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10-6-55 6:35 M.
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Self inflicted 22 cal. rifle

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE **Earl Royer** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **Oct. 6 1955**
DEPUTY MEDICAL EXAMINER ☒ M. D. ASSISTANT MEDICAL EXAM. **HOLLOWAY & COMPANY**

23. BURIAL, CREMATION, REMOVAL (Specify): **Burial** DATE THEREOF **Oct. 9, 1955** NAME OF CEMETERY OR CREMATORY **Wicomico Memorial Park** LOCATION (City, town, or county) (State) **Salisbury, Maryland**

DATE RECD BY LOCAL REG. **10-7-55** REGISTRAR'S SIGNATURE **Mary M. Holloway** 24. FUNERAL DIRECTOR **HOLLOWAY & COMPANY** ADDRESS **SALISBURY MARYLAND**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10262

10285

CERTIFICATE OF DEATH

Items 8,9, FilmG188 11-8-55 et

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Quantico</i>	LENGTH OF STAY (In this place) <i>life</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>X</i>	STREET ADDRESS (If rural give location) <i>Quantico</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>			
3. NAME OF DECEASED (Type or Print) <i>Elizabeth</i> (First) <i>James</i> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <i>10</i> <i>18</i> <i>1955</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Cal</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>wid.</i>	8. DATE OF BIRTH <i>8-11-84</i>
9. AGE last birthday <i>71</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Quantico</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Peters</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-16-7052</i>	
17. INFORMANT & ADDRESS <i>Archie Conway</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>331X</i> IMMEDIATE CAUSE (A) <i>Cerebral Vascular Hemorrhage</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized Arterio sclerosis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>8 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while et work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9/30</i> , 19 <i>51</i> , to <i>10/18</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>10/18</i> , 19 <i>55</i> , and that death occurred at <i>5:30 P.</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Richard H. Saunders</i> M.D.		ADDRESS (Street, city, town, state) <i>Nantuxhe Md.</i>	
DATE SIGNED <i>10/19/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10-23-55</i>	
NAME OF CEMETERY OR-CREMATORY <i>White Horse Cem</i>		LOCATION (City, town, or county) <i>White Horse Md</i>	
24. REC'D BY REGISTRAR <i>Mary H. Holloways</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks W. Lord</i>	
DATE <i>10-25-1955</i>		ADDRESS	

10-11-55

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

10025

Reg. Dist. No.

1. REGULAR HEALTH INSURANCE OR OTHER

2. MARITAL STATUS

3. OCCUPATION

4. PLACE OF BIRTH

5. PLACE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF OTHER

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

BUREAU V. S.

OCT 26 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10249 CERTIFICATE OF DEATH

10263
09200

Dr. Gilmore

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital		STREET ADDRESS (If rural give location) 902 North Division St.					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WALTER (Middle) WOOLFORD (Last) JONES				(Month) Oct. (Day) 2nd (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 14, 1893	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months 2 Days nd		IF UNDER 24 HRS. Hours 19 Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Postal Clerk U.S. Post Office		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kingston, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Jones				14. MOTHER'S MAIDEN NAME Carrie L. Farlow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.K. # 1		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Maddia B. Jones (Wife) 902 S. Div. St. Salisbury, Maryland			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						2 hrs	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Atherosclerosis						2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Hypertension, Essential							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 28, 1955 to Oct 2, 1955 that I last saw the deceased alive on Oct 2, 1955 and that death occurred at 11:28 A.M. from the causes and on the date stated above.							
SIGNATURE David J. Gilmore				ADDRESS (Street, city, town, state) M.D. Camden Ave. Salisbury, Maryland		DATE SIGNED Oct. 4, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 4, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE May H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
DATE Oct 6, 1955							

OCT 6 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10250

CERTIFICATE OF DEATH

10263

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marley Park</u>		<u>02 X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Forrest Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u>		(Middle)		(Last) <u>Khlem</u>		(Month) <u>Oct.</u> (Day) <u>3</u> (Year) <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>2/10/1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY — —		11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar Khlem</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>163X</u> IMMEDIATE CAUSE (A) <u>Cerebral embolism</u>				<u>30 min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca. of the right lung</u>				<u>12 months ?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>2½ months</u>			
<u>Status post pneumonectomy</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 30</u> , 19 <u>55</u> , to <u>Oct. 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 2</u> , 19 <u>55</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. H. H. H.</u>				DATE SIGNED <u>10/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>			
DATE <u>Oct. 10, 1955</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co.</u>			
NAME OF CEMETERY OR CREMATORY <u>Salisbury, Maryland</u>				LOCATION (City, town, or county) <u>Salisbury, Md</u>			
26. ADDRESS (Street, city, town, state)				27. ADDRESS			
<u>Deer's Head State Hospital</u>				<u>Salisbury, Md</u>			
<u>M.D. Salisbury, Maryland</u>				<u>George C. Hill</u>			



BUREAU V. 8.

1955

RECEIVED

10251

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Wicomico</u> MARYLAND			STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u> Route #5, X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>			STREET ADDRESS (If rural give location) <u>Quantico Road</u>		
3. NAME OF DECEASED: (Type or Print) <u>SARAH</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>October 2</u> 19 <u>55</u>		
(First) (Middle) (Last) <u>LARMURE</u>					
5. SEX: <u>Female</u>			9. AGE last birthday <u>84</u> yrs.		
6. COLOR OR RACE: <u>white</u>			10. BIRTHPLACE (State or foreign country): <u>Talbot Co., Md.</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>			11. CITIZEN OF WHAT COUNTRY: <u>USA</u>		
8. DATE OF BIRTH: <u>June 25, 1871</u>			12. CITIZEN OF WHAT COUNTRY: <u>USA</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Corn</u>		
13. FATHER'S NAME: <u>Joseph A. Harrison</u>			14. MOTHER'S MAIDEN NAME: <u>Sarah Kousch</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unky. (If Yes, give war or dates of service)) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT & ADDRESS: <u>Mrs. Charles Nichols Jr.</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.2 IMMEDIATE CAUSE (A) <u>PULMONARY INFARCTION</u>		<u>4-5 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>ANGINA PECTORIS</u>		<u>2-3 mos</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		<u>YRS.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CONGESTIVE HEART FAILURE</u>		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Sept 12, 1955</u> , to <u>Oct. 2, 1955</u> , that I last saw the deceased alive on <u>Oct. 1, 1955</u> , and that death occurred at <u>7:48 AM</u> , from the causes and on the date stated above.		
SIGNATURE <u> Rufus L. Gardner, Jr. M.D.</u>	ADDRESS <u>321 S. Div. St., Salisbury, Md.</u>	DATE SIGNED <u>10/3/55</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>10-4-55</u>	DATE THEREOF <u>10-4-55</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>10-3-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>James Thuman</u>	ADDRESS <u>Pennsauken, N.J.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

OCT 5 1955

RECEIVED

10266

10252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>Since 10/20/55</u>		TOWN <u>Cambridge</u>		<u>09-13-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>102 Choptank Ave.</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>Jacob</u>		(Middle)		(Last) <u>Levy</u>		(Month) (Day) (Year)	
(Type or Print)						<u>Oct. 29 19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 15, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Austria</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Abraham Levy</u>				14. MOTHER'S MAIDEN NAME <u>Annie Faugothner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>220-32-9871</u>		17. INFORMANT & ADDRESS <u>Deceased when admitted to Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 10 mo.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 20, 19 55</u> , to <u>Oct. 29, 19 55</u> , that I last saw the deceased alive on <u>Oct. 29, 19 55</u> , and that death occurred at <u>7:15 p. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>10/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-31-1955</u>	NAME OF CEMETERY OR CREMATORY <u>BALTO. HEBREW</u>		LOCATION (City, town, or county) <u>BALTO.</u>		(State) <u>MD</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	5. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Canton Place</u>			

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10267

Reg. Dist. No.

10286

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>WILLARDS</u>				TOWN <u>WILLARDS</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)				OCT. 28 1955			
RAYMOND CALVIN LEWIS							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
M.	W.	MARRIED	APRIL 15, 1907	48			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MACHINIST HELPER		SHIRT FACTORY		WILLARDS MD		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ERNEST LEWIS				ANNA ELIZABETH TRUITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		MRS. R.C. LEWIS, WILLARD MD			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				Chronic myocarditis			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8:55, 1955, to 10:28, 1955, that I last saw the deceased alive on 10-28, 1955, and that death occurred at 10:28 P.M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Frank Lewis				Willards Maryland		11-1-55	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		11/2/55		LEWIS		WILLARDS MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
NOV 3 1955		Mary H. Holloway		Anna R. Burbay		Burling Md	

CERTIFICATE OF DEATH

Form 10-1-22

1. USUAL RESIDENCE, HOUSE OR PLACE

2. PLACE OF DEATH

3. SEX

4. RACE AND COLOR

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF DISTRICT ATTORNEY

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF VILLAGE CLERK

24. SIGNATURE OF CITY CLERK

25. SIGNATURE OF COUNTY COMMISSIONER

26. SIGNATURE OF TOWNSHIP COMMISSIONER

27. SIGNATURE OF VILLAGE COMMISSIONER

28. SIGNATURE OF CITY COMMISSIONER

29. SIGNATURE OF COUNTY SHERIFF

30. SIGNATURE OF TOWNSHIP SHERIFF

31. SIGNATURE OF VILLAGE SHERIFF

32. SIGNATURE OF CITY SHERIFF

33. SIGNATURE OF COUNTY CLERK

34. SIGNATURE OF TOWNSHIP CLERK

35. SIGNATURE OF VILLAGE CLERK

36. SIGNATURE OF CITY CLERK

37. SIGNATURE OF COUNTY COMMISSIONER

38. SIGNATURE OF TOWNSHIP COMMISSIONER

39. SIGNATURE OF VILLAGE COMMISSIONER

40. SIGNATURE OF CITY COMMISSIONER

41. SIGNATURE OF COUNTY SHERIFF

42. SIGNATURE OF TOWNSHIP SHERIFF

43. SIGNATURE OF VILLAGE SHERIFF

44. SIGNATURE OF CITY SHERIFF

45. SIGNATURE OF COUNTY CLERK

46. SIGNATURE OF TOWNSHIP CLERK

47. SIGNATURE OF VILLAGE CLERK

48. SIGNATURE OF CITY CLERK

49. SIGNATURE OF COUNTY COMMISSIONER

50. SIGNATURE OF TOWNSHIP COMMISSIONER

51. SIGNATURE OF VILLAGE COMMISSIONER

52. SIGNATURE OF CITY COMMISSIONER

53. SIGNATURE OF COUNTY SHERIFF

54. SIGNATURE OF TOWNSHIP SHERIFF

55. SIGNATURE OF VILLAGE SHERIFF

56. SIGNATURE OF CITY SHERIFF

57. SIGNATURE OF COUNTY CLERK

58. SIGNATURE OF TOWNSHIP CLERK

59. SIGNATURE OF VILLAGE CLERK

60. SIGNATURE OF CITY CLERK

61. SIGNATURE OF COUNTY COMMISSIONER

62. SIGNATURE OF TOWNSHIP COMMISSIONER

63. SIGNATURE OF VILLAGE COMMISSIONER

64. SIGNATURE OF CITY COMMISSIONER

65. SIGNATURE OF COUNTY SHERIFF

66. SIGNATURE OF TOWNSHIP SHERIFF

67. SIGNATURE OF VILLAGE SHERIFF

68. SIGNATURE OF CITY SHERIFF

Chlorine suffocation

3/10/22

10-28 22 10-28 22 BUREAU V. S.

10-28 22 10-28 22 10-28 22

RECEIVED

Frank Brown

RECEIVED
MAY 11 1922
BALTIMORE, MD
STATE DEPARTMENT OF HEALTH
RECEIVED
MAY 11 1922
BALTIMORE, MD
STATE DEPARTMENT OF HEALTH

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10253

CERTIFICATE OF DEATH

10268

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 Mon.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sp. Hill Pr. San.</u>				STREET ADDRESS (If rural give location) <u>1012 Riverside Dr.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>SARAH LEWIS MCBRIETY</u>				<u>10 12 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 5, 1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>George Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Rayne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Lewis J. McBriety, Salisbury, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>442X</u>				<u>Cerebral Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Arterio-sclerotic Hypertension with</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>cardio-vascular renal disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>10/11/55</u> to <u>10/11/55</u> , that I last saw the deceased alive on <u>10/11/55</u> and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/14/55</u>		<u>Parsons Cemetery</u>		<u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
		<u>Mary H. Holloway</u>		<u>The Hill & Johnson Co. Salisbury, Md.</u>			
DATE <u>OCT 17 1955</u>				<u>Norman T. Palmer</u>			

(Faint, illegible text)

2015.12.15

1015 Riverside Dr.

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James L. Harrison, 845 Jackson St.

BUREAU V. S.

RECEIVED

THE HILL & JOHNSON CO. CHICAGO, ILL.

22/11/02

1994

10287

10269
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 1 (Shad Point)				STREET ADDRESS (If rural, give location) R.D. # 1 (Shad Point)			
3. NAME OF DECEASED: (First) ROBERT		(Middle) HOWARD		(Last) McCORKLE		4. DATE OF DEATH (Month) (Day) (Year) Oct. 30 th 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: May 1, 1911	9. AGE last birthday: 44 yrs.	IF UNDER 1 YEAR Months 5 Days 29		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Route Man		10b. KIND OF BUSINESS OR INDUSTRY: Newspaper Employee		11. BIRTHPLACE (State or foreign country): Rock Hill S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Jefferson Davis McCorkle				14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Alexander			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY No.: Navy WW II		17. INFORMANT & ADDRESS: Mrs. Visula K. McCorkle (Wife) R.D. # 1 (Shad Point) Salisbury, Maryland			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>24 Hrs Immediate cause (a) Bronchial Asthma, acute.</p> <p>Antecedent cause(s) (b) </p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) </p>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 6		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE **Paul L. Boyer** CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **Oct. 31 1955**
M. D. DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: Nov. 2, 1955	NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery	LOCATION (City, town, or county) (State): Shad Point (Near Salisbury Md.)
DATE REC'D BY LOCAL REG. 10-31-55	REGISTRAR'S SIGNATURE: Mary W. Holloway	24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY SALISBURY MARYLAND	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 3 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10254

CERTIFICATE OF DEATH

10270

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>12 TOWN Salisbury</u>		LENGTH OF STAY (in this place) <u>3 1/2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Marion</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91 Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sadie Lee Meredith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 13 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/25/1883</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Fairmount, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Manie Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>10 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 15</u> , 19 <u>52</u> , to <u>Oct. 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 13</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		DATE THEREOF <u>Oct. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fairmount, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fairmount, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>10-17-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons</u>		ADDRESS <u>Crisfield, Md.</u>	

10255

10271
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 392

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Wicomico</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	
12 TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	12
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>518 Commerce St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Mary Alice Meyers</u>		<u>10 4 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 20, 1918</u>
		9. AGE last birthday: <u>37</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME: <u>Marion Disheroon</u>		14. MOTHER'S MAIDEN NAME: <u>Maggie Parsons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>No</u>	
		17. INFORMANT & ADDRESS: <u>John E. Meyers, 518 Commerce St. Salisbury,</u>	

18. MEDICAL CERTIFICATION		Md. INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>you</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>260X Immediate cause (a)..... <u>Hypoglycemia</u></p> <p>Antecedent cause(s) DUE TO <u>Diabetic Mellitus</u></p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c).....</p>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>10-6-55</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Earl L. Royce CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 10-6-55

M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF: <u>OCT. 6, 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>PARSONS CEMETERY</u>	LOCATION (City, town, or county) (State): <u>SALISBURY, MARYLAND</u>
DATE REC'D BY LOCAL REGISTRY: <u>10-6-55</u>	REGISTRAR'S SIGNATURE: <u>Mary H. Hollaway</u>	24. FUNERAL DIRECTOR: <u>Thomas F. Walker</u>	ADDRESS: <u>Salisbury, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 10 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10256

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>		TOWN <u>West Ocean City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Ocean City</u>		STREET ADDRESS (If rural give location) <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (First) <u>Mealie</u> (Middle) <u>Mitchell</u> (Last)				4. DATE OF DEATH <u>10 - 16 - 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Ahoskey, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jerry Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Betty Hardy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Newport News, Va.</u> <u>Willie Mitchell, 2108 Madison Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.11</u> <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>				Indefinite			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12 Oct.</u> , 19 <u>55</u> , to <u>14 Oct.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>14 Oct.</u> , 19 <u>55</u> , and that death occurred at <u>7:20</u> M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>612 W. Main Salisbury Md. 18045</u> DATE SIGNED <u>18 Oct 55</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Curtis Cemetery</u>		LOCATION (City, town, or county) (State) <u>near Whaleyville, Wore. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>OCT 20 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u> ADDRESS <u>324 E. Church St Salisbury Md.</u>			

10278

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1955

Reg. Dist. No.

1. Name - Complete Name of Deceased

2. Date of Death

3. Sex - Male Female

4. Race

5. Birth Date

6. Birth Place

7. Usual Residence

8. Cause of Death

9. Place of Death

10. Signature of Physician

11. Date of Report

12. Signature of Registrar

13. Date of Entry

14. Signature of Hospital

15. Date of Burial

16. Signature of Burial

17. Date of Cremation

18. Signature of Cremation

19. Date of Autopsy

20. Signature of Autopsy

21. Date of Dissection

22. Signature of Dissection

23. Date of Embalming

24. Signature of Embalming

25. Date of Interment

26. Signature of Interment

27. Date of Reinterment

28. Signature of Reinterment

29. Date of Exhumation

30. Signature of Exhumation

31. Date of Disposition

32. Signature of Disposition

33. Date of Return

34. Signature of Return

35. Date of Release

36. Signature of Release

37. Date of Transfer

38. Signature of Transfer

39. Date of Discharge

40. Signature of Discharge

41. Date of Admission

42. Signature of Admission

43. Date of Discharge

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93. Date of Admission

94. Signature of Admission

RECEIVED

OCT 20 1955

BUREAU V. S.

RECEIVED

10288

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10273

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN (Rural) Pittsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route # 50				STREET ADDRESS (If rural, give location) 511 Jackson St.		1	
3. NAME OF DECEASED: (First) MILTON		(Middle) LEONARD		(Last) MITCHELL		4. DATE OF DEATH (Month) (Day) (Year) OCT. 29 19 55	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: May 13, 1893	
9. AGE last birthday: 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Produce Broker Fruit & Produce		11. BIRTHPLACE (State or foreign country): Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Mitchell				14. MOTHER'S MAIDEN NAME: Annie B. Holland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Minnie Cropper (Sister) Ocean City, Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
816X Immediate cause (a) Crushed chest DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, place bldg., etc.) OF INJURY Pittsville Wicomico		21c. (City or town) (County) (State) md	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10 29 55 11:30 AM				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Collision with Chondron	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Carl L. Rye				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> Oct. 31 1955			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Nov. 2, 1955		Parsons Cemetery		Salisbury, Maryland	
DATE REC'D BY LOCAL REG. 10-31-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 3 1955

BUREAU A. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10257

CERTIFICATE OF DEATH

10274

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>About 30 yrs.</u>		TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - 332 Catherine St.</u>				STREET ADDRESS (If rural give location) <u>332 Catherine Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Samuel James Pitts</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 15 - 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>A.A.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>About 1860</u>	
9. AGE last birthday <u>About 95 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin, Worcester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel James Pitts</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Penniwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes - lost</u>		17. INFORMANT & ADDRESS <u>Thomas L. Pitts, R.R. Ave. Berlin, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>593X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Glomerulonephritis</u>				<u>6 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 Oct</u>, 19<u>55</u>, to <u>15 Oct</u>, 19<u>55</u>, that I last saw the deceased alive on <u>15 Oct</u>, 19<u>55</u>, and that death occurred at <u>3:30 P.</u>M, from the causes and on the date stated above.							
SIGNATURE <u>Dunnell</u>		DATE THEREOF <u>10-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Berlin, Worcester Co., Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church St Salisbury Md.</u>	

OCT 20 1955

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1955

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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CAUSE OF DEATH

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BUREAU V. 8

OCT 20 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10258

CERTIFICATE OF DEATH

10275

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>302 Delaware Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Richard Purnell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 2 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>7-29-'07</u>	
9. AGE last birthday <u>48 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bruce Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Barclay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-3914</u>		17. INFORMANT & ADDRESS <u>Mrs. Sara W. Purnell 302 Delaware St. Salisbury, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
593X IMMEDIATE CAUSE (A) <u>sepsis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>glomerulonephritis</u>						<u>6 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>2 April, 1955</u>, to <u>2 Oct., 1955</u>, that I last saw the deceased alive on <u>2 Oct., 1955</u>, and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. Purnell, MD</u>		DATE THEREOF <u>10-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury Wicomico Co. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mary A. Stewart</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>324 G. Church St. Salisbury, Md.</u>	
DATE <u>Oct. 10, 1955</u>							

BUREAU V. S.

1955

RECEIVED

10259

10276

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital		STREET ADDRESS (If rural, give location) Ocean City Rd. #R.D. #3	
3. NAME OF DECEASED:	(First) WILLIE	(Middle) ANNA	(Last) REDDISH
4. DATE OF DEATH	(Month) OCT.	(Day) 16th	(Year) 19 55
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: May 22, 1879
9. AGE last birthday: 76 yrs.		IF UNDER 1 YEAR: Months 4 Days 24	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): House Work		10b. KIND OF BUSINESS OR INDUSTRY: at Home	11. BIRTHPLACE (State or foreign country): Quantico, Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: James Phippin		14. MOTHER'S MAIDEN NAME: Ianthan Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: Mrs. Leroy Smith (Daughter) Ellegood St. (Pemberton) Salisbury, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) Severely Perforated Bladder			3 days
Antecedent cause(s) (b) Chronic Cystitis			3 days
DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last (c)			3 months
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 10-13-55		19b. MAJOR FINDING OF OPERATION: Perforated Bladder	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home	21c. (City or town) Salisbury (County) Wicomico (State) MD	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: 10 13 55 A.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Perforated Bladder	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Oct. 18 1955 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: Oct. 20, 1955	NAME OF CEMETERY OR CREMATORY: Parsons Cemetery	LOCATION (City, town, or county) (State): Salisbury, Maryland
DATE REC'D BY LOCAL REG: 10-18-55	REGISTRAR'S SIGNATURE: Mary W. Holloway	24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY SALISBURY MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 20 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10277
10289 CERTIFICATE OF DEATH

Reg. Dist. No. 10277

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write name and nearest town)	LENGTH OF STAY (If at this place)	CITY (If outside corporate limits, write name and nearest town)	OR TOWN
<i>Willards</i>	<i>Life</i>	<i>Willards</i>	<i>Willards</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<i>Arnold Sidney Richardson</i>		<i>Oct 10 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Jan 16, 1882</i>
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY	
<i>73 yrs</i>		<i>own farm</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S M maiden NAME:	
<i>Sidney Richardson</i>		<i>Margaret Ellen Parsons</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service		16. SOCIAL SECURITY NO.	
<i>Yes</i>		<i>—</i>	
17. INFORMANT & ADDRESS:			
<i>Mrs Lillie Richardson Willards, Md.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE		
(A) <i>Cerebral occlusion of the brain</i>		<i>2 hrs.</i>
ANTECEDENT CAUSE (B)		
(B) <i>Hypertension, arteriosclerosis</i>		<i>10 yrs</i>
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1945*, 19, to *10-10*, 1955, that I last saw the deceased alive on *10-10*, 1955, and that death occurred at *3:45 P.M.* from the causes and on the date stated above.

SIGNATURE <i>Frank Lewis</i>	ADDRESS <i>Willards Md</i>	DATE SIGNED <i>10-11-55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>Oct 13 1955</i>	<i>Pittsville</i>
LOCATION (City, town, or county) (State)		
<i>Pittsville Md.</i>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>10-14-55</i>	<i>Mary W. Holloman</i>	<i>Peter Thaly Schayzull, Ill.</i>
		ADDRESS

BUREAU V. S.

OCT 17 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10260

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11387

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Accomac</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>10 min.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Wattsville,</u> 83x3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) ✓			
3. NAME OF DECEASED: (Type or Print) <u>James</u> <u>T</u> <u>Robinson</u>			4. DATE OF DEATH <u>10-30-55</u> <u>19</u>				
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 15, 1907</u>	9. AGE last birthday: <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Civil Service</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>James O. Robinson</u>				14. MOTHER'S MAIDEN NAME: <u>Katie Prister</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>✓</u> <u>2nd World War</u>			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Grace Robinson, Wattsville, Va.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							1 hr. 10 min.
Immediate cause (a) <u>Fractured skull</u>							
DUE TO							
Antecedent cause(s) (b) _____							
Diseases or conditions, if any, giving rise to the above cause (c) _____							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (City or town) (County) (State) <u>Wattsville ; Accomac, 88 Virginia</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10-30-55 3:40 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down the cellar steps at home.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Royce</u>		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>10-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Nov. 2, 1955</u>		NAME OF CEMETERY <u>John Taylor Memorial</u>		LOCATION (City, town, or county) (State) <u>Temperanceville, Va.</u>	
DATE REC'D BY LOCAL REG. <u>11-2-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>William B. Sayer - Christman, Va.</u>		ADDRESS	

BUREAU V. 3

NOV 17 1955

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death.
The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10261

CERTIFICATE OF DEATH

10278
338

Reg. Dist. No. 290

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>	<u>3 1/2</u> months	TOWN <u>Easton</u>	<u>20X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS	(If rural give location)	
<u>Deer's Head State Hospital</u>	<u>Route # 4, Box 68</u>		
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Emma E. Ross</u>		<u>Oct. 12 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>3/12/1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Unknown</u>		<u>--</u>	<u>Maryland</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>John Lewis Mullekin</u>		<u>Louise Winterbottom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<u>Unk.</u>			<u>Hospital Records</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
463X IMMEDIATE CAUSE (A) <u>Coronary embolism</u>			<u>30 minutes</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombo phlebitis - left femoral vein</u>			<u>7 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis - general</u>			<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>6/21</u> , 19 <u>55</u> , to <u>Oct. 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 12</u> , 19 <u>55</u> , and that death occurred at <u>4:00P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>L.V. Maldve</u>		DATE SIGNED <u>10/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		ADDRESS (Street, city, town, state)	
<u>Burial</u>		<u>Deer's Head Hospital Salisbury, Maryland</u>	
DATE THEREOF <u>Oct. 15/55</u>		LOCATION (City, town, or county) (State)	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		<u>Easton Md.</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Furman</u>	
DATE <u>10/14/55</u>		ADDRESS	

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10279

10290

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>47 Yrs.</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Rt# 2</u>				<u>Spring Hill Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LAURA POWELL ROUNDS</u>				<u>10 23 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 29, 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Josiah Powell</u>				<u>Sallie Brittingham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Julia R. Twilley, Quantico, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>Arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 17th</u> , 19 <u>55</u> , to <u>Oct. 23rd</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 23rd</u> , 19 <u>55</u> , and that death occurred at <u>10:05 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William E. Enrich</u> M. D.				ADDRESS (Street, city, town, state) <u>Helena Md</u> DATE SIGNED <u>Oct 24 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/25/55</u>		<u>Parsons Cemetery</u>		<u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-25-55</u>		<u>Mary W. Hollaway</u>		<u>Norman F. Baker</u>		<u>The Hill & Johnson Co. Salisbury, Maryland</u>	

10537

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Form D. 1-10

1. Usual Residence of Deceased

1000 Maryland
Baltimore

2. Date and
Place of Birth

March 10
Baltimore

3. Date of Death

May 2

4. Cause of Death

5. Manner of Death

6. Place of Death

7. Date of Burial

8. Place of Burial

9. Name of Physician

10. Name of Undertaker

11. Name of Coroner

12. Name of Registrar

13. Name of Medical Examiner

14. Name of Hospital

15. Name of Doctor

BUREAU V. S.

16. Date of Report

RECEIVED

17. Name of Registrar

18. Name of Coroner

19. Name of Medical Examiner

RECEIVED
DIVISION OF MEDICAL INVESTIGATION
MAY 10 1935
BALTIMORE, MARYLAND

Dr. Brice

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10280

10262

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Seaford</u>		RURAL <u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>B.F.D. #2</u>		<u>SEAFORD-LAUREL HIGHWAY</u>	
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>RUST</u> (Last) <u>Sampson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct.</u> <u>27</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>MARRIED</u>		8. DATE OF BIRTH: <u>MARCH 27, 1981</u>	
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>BUILDING CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country): <u>BRIDGEVILLE, DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>CHARLES SAMPSON</u>				14. MOTHER'S MAIDEN NAME: <u>SARAH BAKER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY No. <u>214-12-6853</u>		17. INFORMANT & ADDRESS: <u>MRSIDA A. SAMPSON; SEAFORD, DEL.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>156.1</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>			
ANTECEDENT CAUSE (S) DUE TO <u>Carcinoma of liver</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>10-9</u> , 19 <u>55</u> , to <u>10-27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-26</u> , 19 <u>55</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Brice</u>				ADDRESS <u>M.D. 226 N. Division</u>		DATE SIGNED <u>10-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>OCT 30, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>BRIDGEVILLE CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BRIDGEVILLE, DELAWARE</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-31-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>MEDFORD L. WATSON; SEAFORD, DELAWARE</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 3 1955

BUREAU V. S.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10263

CERTIFICATE OF DEATH

10281

Reg. Dist. No. 327

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>					
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)					
12 TOWN <u>Salisbury</u>		12 TOWN <u>Salisbury</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
00 147 Upton Street		147 Upton Street					
3. NAME OF DECEASED (First) (Middle) (Last)							
Arthur Milton Scott							
4. DATE OF DEATH (Month) (Day) (Year)							
Oct. 24 19 55							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH				
Male	White	Married	June 11, 1891				
9. AGE last birthday		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)					
64 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY					
Lumberman		Lumber					
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Maryland		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Arthur W. Scott		Ida Bodboy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.					
no		no					
17. INFORMANT & ADDRESS							
Donald P. Scott, Salisbury, Md.							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
434.1 IMMEDIATE CAUSE (A) <u>longest heart failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>cor pulmonale</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>pulmonary fibrosis</u>							
0028 <u>pulmonary tuberculosis</u>							
19. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)					
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White et work Not while et work					
22. I hereby certify that I attended the deceased from <u>Mar. 19 55</u> , to <u>Oct 24 19 55</u> , that I last saw the deceased alive on <u>Oct 24 19 55</u> , and that death occurred at <u>8:58 P.</u> M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)					
<u>Donald P. Scott</u>		<u>Salisbury, Md.</u>					
M. D.		DATE SIGNED					
		<u>10/25/55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF					
Burial		10/26/1955					
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)					
Wicomico Mem. Park		Salisbury, Maryland					
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE					
DATE <u>Oct. 28, 1955</u> <u>Mary H. Hollaway</u>		<u>Thomas H. Hallam</u> <u>Salisbury, Md.</u>					

NOTIFICATION

1. This form is to be filled out by the physician or other person who has attended the deceased, and is to be filed in the office of the Registrar of Deaths, Baltimore, Maryland, within ten days of the date of death. It is to be filled out in duplicate, and the original is to be retained in the office of the Registrar of Deaths, Baltimore, Maryland, and the duplicate is to be forwarded to the office of the Registrar of Deaths, Washington, D.C., by the first available mail.

CERTIFICATE OF DEATH

10551

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

10551

1. PLACE OF DEATH		2. MANNER OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. RACE	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. OCCUPATION		12. EDUCATION	
13. PREVIOUS ILLNESS		14. CAUSE OF DEATH	
15. MEDICAL OPINION		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS	

BUREAU V. S.

BUREAU V. S.

OCT 28 1955

OCT 27 1955

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10264 CERTIFICATE OF DEATH

10282

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke</u>		<u>23-42-2</u>	
TOWN <u>Salisbury</u>				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>October 6 - 1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Sep.</u>		8. DATE OF BIRTH: <u>Feb. 5, 1903</u>	
9. AGE last birthday <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>farming</u>		11. BIRTHPLACE (State or foreign country): <u>Florida</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>farming</u>		11. BIRTHPLACE (State or foreign country): <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Julius Summers</u>				14. MOTHER'S MAIDEN NAME: <u>Maggie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT'S ADDRESS: <u>Martha Ross</u>							

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
157X IMMEDIATE CAUSE (A) <u>Carcinoma of pancreas & metastases</u>		2 month
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of pancreas & metastases.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury (street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-19-</u> , 19 <u>53</u> , to <u>10-6-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-5-</u> , 19 <u>55</u> , and that death occurred at <u>4:35</u> A.M., from the causes and on the date stated above.					
SIGNATURE <u>William T. Johnson</u>		M.D. <u>Sabehy</u>		DATE SIGNED <u>10-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>10-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wharton Memorial</u>	
				LOCATION (City, town, or county) (State) <u>Parkersburg, Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-8-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Savage</u>	
				ADDRESS <u>New Church, Va</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 11 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10291

CERTIFICATE OF DEATH

10283

Reg. Dist. No. 336

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Delmar		20 yrs		TOWN Delmar			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
210 Maryland				210 Maryland Ave,			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Anna		(Middle) Agnes		(Last) Tamosaitis		(Month) (Day) (Year)	
						Oct. 13 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Married	Nov. 3, 1911	43 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
At Home		Home		Mass.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Yankas				Marian Garratt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		221-16-0028		Marian Stokes, Delmar, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 months	
580X IMMEDIATE CAUSE (A) Subacute yellow atrophy of the liver							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from August , 19 55 , to October 13 , 19 55 , that I last saw the deceased alive on October 13 , 19 55 , and that death occurred at 4:50 A.M., from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
[Signature]		M.D. 303 East Street, Delmar Md.		10-14-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10-17-55		Mt Olive		Delmar, Delaware	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 18, 1955		Harry E. Hudson		W. S. Grand		Delmar, Md.	

RECEIVED

OCT 18 1955

BUREAU V. S.

1. NAME OF DECEASED		2. PLACE OF BIRTH	
JAMES EARL RAY		MEMPHIS, TENNESSEE	
3. DATE OF DEATH		4. CAUSE OF DEATH	
APRIL 4, 1968		SHOOTING	
5. PLACE OF DEATH		6. NAME OF PHYSICIAN	
MEMPHIS, TENNESSEE		DR. JAMES H. HAYES	
7. NAME OF FUNERAL HOME		8. NAME OF BURIAL PLACE	
FARMER'S BURIAL HOME		GREENWOOD CEMETERY	
9. NAME OF WITNESS		10. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
11. NAME OF WITNESS		12. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
13. NAME OF WITNESS		14. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
15. NAME OF WITNESS		16. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
17. NAME OF WITNESS		18. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
19. NAME OF WITNESS		20. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
21. NAME OF WITNESS		22. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
23. NAME OF WITNESS		24. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
25. NAME OF WITNESS		26. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
27. NAME OF WITNESS		28. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
29. NAME OF WITNESS		30. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
31. NAME OF WITNESS		32. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
33. NAME OF WITNESS		34. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
35. NAME OF WITNESS		36. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
37. NAME OF WITNESS		38. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
39. NAME OF WITNESS		40. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
41. NAME OF WITNESS		42. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
43. NAME OF WITNESS		44. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
45. NAME OF WITNESS		46. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
47. NAME OF WITNESS		48. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
49. NAME OF WITNESS		50. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
51. NAME OF WITNESS		52. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
53. NAME OF WITNESS		54. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
55. NAME OF WITNESS		56. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
57. NAME OF WITNESS		58. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
59. NAME OF WITNESS		60. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
61. NAME OF WITNESS		62. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
63. NAME OF WITNESS		64. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
65. NAME OF WITNESS		66. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
67. NAME OF WITNESS		68. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
69. NAME OF WITNESS		70. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
71. NAME OF WITNESS		72. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
73. NAME OF WITNESS		74. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
75. NAME OF WITNESS		76. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
77. NAME OF WITNESS		78. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
79. NAME OF WITNESS		80. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
81. NAME OF WITNESS		82. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
83. NAME OF WITNESS		84. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
85. NAME OF WITNESS		86. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
87. NAME OF WITNESS		88. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
89. NAME OF WITNESS		90. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
91. NAME OF WITNESS		92. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
93. NAME OF WITNESS		94. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
95. NAME OF WITNESS		96. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
97. NAME OF WITNESS		98. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	
99. NAME OF WITNESS		100. NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10543

NOTED AND JACOBUS OF
THE STATE OF
THE DEPARTMENT OF HEALTH
BALTIMORE, MD
OCT 18 1955

10265

CERTIFICATE OF DEATH

10284

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		2 days		TOWN Delmar			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS (If rural give location) 402 East Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Martha (Middle) Jane (Last) Thawley				(Month) Oct. (Day) 16 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Sept. 27, 1881	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin Moore				14. MOTHER'S MAIDEN NAME Gordy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Frank Thawley, Delmar, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage						2 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE Willen B. Ellis Jr. M.D.				ADDRESS (Street, city, town, state) Salisbury, Md.		DATE SIGNED 10-18-55 (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-19-55		NAME OF CEMETERY OR CREMATORY Meltons		LOCATION (City, town, or county) Delmar, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary W. Hallways		25. FUNERAL DIRECTOR'S SIGNATURE W. S. Marshall Co - Delmar, Md.		ADDRESS	
DATE OCT 19 1955							

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL HEALTH OFFICE OF DISTRICT

NAME OF DECEASED

DECEASED

AGE AND SEX

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

SEX

CAUSE OF DEATH

CAUSE OF DEATH

SEX

DATE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

OCT 19 1955

RECEIVED

DATE OF DEATH

DATE OF DEATH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10266

CERTIFICATE OF DEATH

10285

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury, Maryland		LENGTH OF STAY (in this place) 2yr. 5mo. 19days		CITY (If outside corporate limits, write RURAL and give nearest town) Town Trappe, Maryland		20X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 91 Deer's Head State Hospital				STREET ADDRESS (If rural give location) ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Helen (Middle) Virginia (Last) Towers				(Month) Oct. (Day) 2 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH Aug. 11, 1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William A. Gambrill				14. MOTHER'S MAIDEN NAME Annie V. Ornett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						7 days	
IMMEDIATE CAUSE (A) Uremia							
ANTECEDENT CAUSE(S) DUE TO (B) Interacapillary glomerulosclerosis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 260X							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive cardiovascular disease Diabetes Mellitus						3 yrs 4 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr. 13, 19 53 , to Oct. 2, 19 55 , that I last saw the deceased alive on Oct. 2, 19 55 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above.							
SIGNATURE M. Maldie				ADDRESS (Street, city, town, state) Salisbury, Maryland		DATE SIGNED 10/3/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF Oct 5 55		NAME OF CEMETERY OR CREMATORY Spring Hill		LOCATION (City, town, or county) Eastern (State) MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary W. Holloman		25. FUNERAL DIRECTOR'S SIGNATURE C. H. ...		ADDRESS Eastern	
DATE 10-18-55							

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10267

CERTIFICATE OF DEATH

10286

Dr. Carrie Hearn

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 82 Peh. Gen. Hospital				STREET ADDRESS (If rural give location) 905 Hanover St.		1	
3. NAME OF DECEASED (First) (Middle) (Last) MATILDA S TRADER				4. DATE OF DEATH (Month) (Day) (Year) OCT. 17th 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 14, 1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Belfast Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James McClosky				14. MOTHER'S MAIDEN NAME Unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mr. Ralph Williams-Lloyd & Hanson St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 331X Right Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) arteriosclerosis + hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) arteriosclerosis +							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 8, 1955, to Oct 17, 1955, that I last saw the deceased alive on Oct 17/55, and that death occurred at 5:35 AM, from the causes and on the date stated above.							
SIGNATURE Carrie Hearn				DATE SIGNED Oct 18 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 19, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR OCT 19 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

BUREAU V. 3

OCT 19 1955

RECEIVED

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10268

CERTIFICATE OF DEATH

10287

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>12</u> TOWN <u>Salisbury</u>		<u>5 Yrs.</u>		<u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		<u>1</u>	
<u>00</u> <u>At home - 514 Delaware Ave.</u>				<u>514 Delaware Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Laura Jones Tull</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 20 - 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Wicomico Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Nutter</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Nutter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Norris Jones, 514 Del. St. Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.0</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Feb. 19 55</u> , to <u>20 Oct 19 55</u> , that I last saw the deceased alive on <u>20 Oct 19 55</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>F. J. Purnell</u>		M.D. <u>652 W. Main</u>		ADDRESS (Street, city, town, state) <u>Salisbury Md 21805</u>		DATE SIGNED <u>23 Oct 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Vernon, Somerset Co. Md.</u>	
24. REC'D BY REGISTRAR <u>DATE OCT 25 1955</u>		REGISTRAR'S SIGNATURE <u>Mary St. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church Street Salisbury, Maryland</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Oct 20 1965		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

RECEIVED
OCT 20 1965
BUREAU V. 2

1. The death of a person is a public health problem and the State Department of Health is interested in the cause of death and the manner of death. The death of a person is a public health problem and the State Department of Health is interested in the cause of death and the manner of death.

DA Long

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10288

10269

Items 8, 9, Film 11-1-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

332

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Upper Hill</i>		19X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>Box 44</i>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>George Waters</i>				OF DEATH: <i>October 9 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Married</i>		8. DATE OF BIRTH <i>1889</i>	
9. AGE last birthday <i>66 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Seafarer</i>		11. BIRTHPLACE (State or foreign country): <i>Upperhill</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Robert Waters</i>				14. MOTHER'S MAIDEN NAME: <i>Aurelia Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <i>no</i>		16. SOCIAL SECURITY NO. <i>212-16-1750</i>		17. INFORMANT & ADDRESS: <i>Mrs. Maude Waters, Upperhill, Md.</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Carcinoma of Stomach</i>				2 wks.			
ANTECEDENT CAUSE (S) DUE TO (B) <i>perforation.</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Process of upper peritoneal cavity.</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <i>8:12</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>William H. Fisher</i>				ADDRESS <i>Salisbury, Md.</i>		DATE SIGNED <i>10-11-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Oct 12-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Centennial</i>		LOCATION (City, town, or county) (State) <i>Farmington Somerset Co Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>10-11-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>		FUNERAL DIRECTOR <i>Charles H. Ward</i>		ADDRESS <i>Marion Star, Md.</i>	

VS. A15 — 10-53

BUREAU V. M.

OCT 13 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10292

CERTIFICATE OF DEATH

10289

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland COUNTY Wicomico		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN Fruitland		LENGTH OF STAY (in this place) 35 yrs.		TOWN Fruitland		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS /			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ANNIE		(Middle) BANKS		(Last) WATSON		(Month) 10 (Day) 31 (Year) 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 9, 1888		9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas L. Banks				14. MOTHER'S MAIDEN NAME Virginia Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 218-20-5442		17. INFORMANT & ADDRESS B. Franklin Watson ----- Same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 2 wks			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953 , 19....., to 10-31 , 19....., 55 that I last saw the deceased alive on 10-31 , 19....., and that death occurred at 10:50 P.M. from the causes and on the date stated above.							
SIGNATURE Lu L. Lowry M.D.				ADDRESS (Street, city, town, state) Fruitland, Md DATE SIGNED 11-1-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/3/1955		NAME OF CEMETERY OR CREMATORY St. John's Cemetery		LOCATION (City, town, or county) Fruitland, Maryland (State)	
24. REC'D BY REGISTRAR NOV 7 1955		REGISTRAR'S SIGNATURE Mary F. Hallaway		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Md. Address Salisbury, Md.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED John H. H. H.		2. SEX Male		3. AGE 35 yrs.		4. RACE White		5. BIRTH DATE Jan. 9, 1888		6. BIRTH PLACE Maryland		7. MARRIAGE DATE Jan. 1, 1915		8. MARRIAGE PLACE Maryland		9. OCCUPATION Teacher		10. CAUSE OF DEATH Heart Disease		11. PLACE OF DEATH Home		12. SIGNATURE OF PHYSICIAN J. H. H.		13. SIGNATURE OF WITNESSES J. H. H.	
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BUREAU V. E.

NOV 2 1935

RECEIVED

The Hall & Johnson Co.

RECEIVED
DIVISION OF HEALTH
BALTIMORE, MARYLAND
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10270

CERTIFICATE OF DEATH

10290

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>SALISBURY</u>				TOWN <u>Chincoteague</u>		83x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>Spring Hill - Pvt. Savi.</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>ANNIE</u>				<u>White</u>		<u>Oct. 3 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>White</u>	<u>Widowed</u>	<u>JUNE 6, 1864</u>	<u>91</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Girdle tree</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas Skirgis</u>				<u>Elizabeth Jane Telghman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. Vesta Howard Chincoteague</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Cardio-vascular renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/6</u> , 19 <u>55</u> , to <u>10/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-1</u> , 19 <u>55</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Phyllis A. Leahy</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>10-3-55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>10/15/55</u>		<u>St. James</u>		<u>Salisbury Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>10-7-55</u>		<u>Mary W. Holloman</u>		<u>Walter M. Clark Chincoteague</u>		<u>Va</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE (NAME OF DECEASED)

DATE OF DEATH

MARKED

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BUREAU V. S.

OCT 10 1914

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10271

CERTIFICATE OF DEATH

10291

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>4 years</u>		TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>262 W. Biddle Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Joshua</u> <u>White</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct.</u> <u>13</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/20/1881</u>		9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John White</u>				14. MOTHER'S MAIDEN NAME <u>Anna White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease with aortic insufficiency</u>						<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Residual right hemiplegia due to an old cerebral thrombosis</u>						<u>6 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sep. 14, 1951</u> , to <u>Oct. 13, 1955</u> , that I last saw the deceased alive on <u>Oct. 13, 1955</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u>		<u>V. Juerman, M.D.</u>		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital</u> <u>Salisbury, Maryland</u>		DATE SIGNED <u>10/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wheatland Cem.</u>		LOCATION (City, town, or county) (State) <u>Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker H. H. H.</u>		ADDRESS	
DATE <u>OCT 25 1955</u>							

2

10-2-23 - Theater Co.

[Faint handwritten signature]

RECEIVED

OCT 25 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Royer, Earl (Med Exam.)

10292

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 832

1. PLACE OF DEATH: 10272				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
12 TOWN Salisbury		2000		TOWN Salisbury		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
822 Pen. Gen. Hospital				R.D. # 5 (Quantico Road)			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
WILLIAM		CANNON		WHITE		October 6th 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	Married	Oct. 4th, 1888	67	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farming (on Homestead Farm)				Near Snow Hill Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William H. White				Annie Short			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS			
Unk				Mrs. Ada C. White (Wife) R.D. # 5 Salisbury, Maryland			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a)..... Coronary Occlusion							
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c).....							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input checked="" type="checkbox"/> Oct. 6 1955			
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 8, 1955		Methodist Cemetery		Snow Hill, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
18-7-55		Mary W. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

BUREAU V. S.

OCT 10 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10293

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico County		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) About 30 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - 327 Poplar Hill Ave.				STREET ADDRESS (If rural, give location) 327 Poplar Hill Avenue		1	
3. NAME OF DECEASED: (Type or Print) Cassale		(First) (Cassale)		(Last) Wilson		4. DATE OF DEATH (Month) 10 (Day) 9 (Year) 1955	
5. SEX: Female	6. COLOR OR RACE: A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: About 1875	9. AGE last birthday: About 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Seamstress		10b. KIND OF BUSINESS OR INDUSTRY: Own business		11. BIRTHPLACE (State or foreign country): Chester, Delaware Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joseph Preston				14. MOTHER'S MAIDEN NAME: Mary Louise Rigby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Ella Covington, 417 Edward St. Chester, Pa.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
443x Immediate cause (a) Bronch - pneumonia DUE TO Antecedent cause(s) (b) Hypertensive E. J. Dr... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						Days	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE John Boy		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. 10-17-55					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 10-17-55		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
DATE REC'D BY LOCAL REG. 10-18-55		REGISTRAR'S SIGNATURE Mary W. Holloman		24. FUNERAL DIRECTOR Mary A. Stewart ADDRESS 324 E. Church St. Salisbury, Md.			

BUREAU V. S.

OCT 20 1935

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10294
10274 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>12 TOWN Salisbury</u>		LENGTH OF STAY (in this place) <u>6 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Princess Anne</u> <u>19X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 P.G. Hospital</u>				STREET ADDRESS (If rural give location) <u>R.F.D.3</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Frank Windsor</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 6</u> <u>1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>married</u>	8. DATE OF BIRTH: <u>Sept. 24, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Windsor</u>				14. MOTHER'S MAIDEN NAME: <u>Stella Loria</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mr. Paul Windsor Princess Anne, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>3-4 wks</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Bilat. Pyelonephritis</u>						<u>4-5 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Carcinoma Bladder</u>						<u>2 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Sept 6, 1955</u>		19B. MAJOR FINDINGS OF OPERATION <u>Spreading Carcinoma of Bladder</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 6, 1955</u> to <u>Oct 6, 1955</u> that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>55</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Long</u>		ADDRESS <u>226 N. Dumfries St</u>		DATE SIGNED <u>10/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-9-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery</u>		LOCATION (City, town, or county) (State) <u>Oriole, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-8-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Levin R. Wilson</u>		ADDRESS <u>Princess Anne, Maryland</u>	

BUREAU V. S.

OCT 11 1955

RECEIVED

10275

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>Salisbury</u>				23x-2 <u>Berlin</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED: (Type or Print)			4. DATE (Month) (Day) (Year)				
(First) (Middle) (Last)			OF DEATH				
<u>Henry</u>			<u>October 6</u>			<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		
<u>male</u>	<u>C</u>		<u>June 10, 1901</u>	<u>54</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>laborer</u>		<u>Farming</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Steve Young</u>				<u>Emma Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>9</u>				<u>—</u>		<u>Hattie Young</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
157X IMMEDIATE CAUSE						<u>6 Mon</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>21 Hour</u>	
(A) <u>Carcinoma of Pancreas</u>							
DUE TO							
(B) <u>Carotid A. West</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>Oct. 5, 1955</u>							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-28</u> , 1955, to <u>10/6</u> , 1955, that I last saw the deceased alive on <u>10/6</u> , 1955, and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>John M. Bledsoe</u>				<u>M.D. Salisbury</u>		<u>Oct. 10/7/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>10-9-55</u>		<u>Wharton Memorial</u>		<u>Parkersley, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-8-55</u>		<u>Mary W. Holloman</u>		<u>Edgar Wharton</u>		<u>New Church</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 11 1965

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